IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION AT CINCINNATI

DURAMED PHARMACEUTICALS, INC., )
)
Plaintiff )
vs. ) CIVIL ACTION
) NO. C-1-00-735
WYETH-AYERST LABORATORIES, INC., )
)
Defendant )

**********

ORAL AND VIDEOTAPED DEPOSITION OF
DALE BYSTROM
HIGHLY CONFIDENTIAL
JULY 18, 2002

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Oral deposition of DALE BYSTROM, produced as a witness at the instance of the Defendant and duly sworn, was taken in the above-styled and numbered cause on the 18th of July, 2002, from 10:01 a.m. to 4:37 p.m., before Susan T. Baker, RDR, Certified Shorthand Reporter and Notary Public in Harris County, for the State of Texas, reported by machine stenography, at the offices of Susman Godfrey, LLP, 1000 Louisiana, Suite 5100, Houston, Texas, pursuant to the Federal Rules of Civil Procedure, Notice and the agreement of counsel that:

The original signature page of this deposition shall be forwarded to the attorney for Plaintiff, who shall obtain the signature of the witness before any notary public within 30 days prior to returning same to the court reporter for appropriate filing. Failing that, a copy of this deposition can be used at the time of trial with the same validity as if it were the original.





A P P E A R A N C E S

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VIDEOGRAPHER:
Scott Michael
Steve Michael





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THE VIDEOGRAPHER: Date is July 18th, 2002. We are on the record at 10:01.

DALE BYSTROM,

having been first duly sworn, testified as follows:

EXAMINATION

Q. (BY MR. EGGERT) Sir, could you please state your name for the record?

A. My name is Dale Bystrom.

Q. Mr. Bystrom, my name is David Eggert. I'm an attorney with Arnold & Porter in Washington, D.C., and I represent the -- and I need to put on my microphone. And I represent the Defendant in this case, Wyeth-Ayerst Pharmaceuticals. We will be taking your deposition today.

I take it you've not had your deposition taken before?

A. Not as an expert witness. I have been deposed before, however.

Q. What's the context in which you've been deposed previously?

A. I was deposed in an arbitration case between a retail pharmacy and a PBM, and I was an employee of the pharmacy at that time; and I was also deposed many years ago as an employee during a case between myself and a previous employer.





Q. In connection with the arbitration concerning a pharmacy and a PBM, was the pharmacy Long Drug Stores?

A. Yes.

Q. And what was the nature of the dispute with the PBM in that case?

A. The nature of the dispute was over reimbursement for claims that had been submitted.

Q. And who was it who was claiming reimbursement?

A. There was a dispute over the amount of reimbursement that should have been submitted. The PBM was suing Longs Drug Stores for additional payment that they felt was due them.

Q. I see. It felt that Long Drug Store had submitted reimbursements that were higher than were authorized under its arrangement with the --

A. No, that's no correct. They had interpreted the reimbursement agreement differently than Longs Drug Stores had interpreted the reimbursement agreement.

Q. And who was the PBM involved in that case?

A. MedImpact.

Q. And how was that case resolved?

A. Longs was victorious 100 percent in the





arbitration.

Q. And was that the end of the matter --

A. Yes.

Q. -- or did it proceed?

A. No, it did not.

Q. One thing one thing I should say is that I'll be asking questions today during the course of the deposition. If at any time you don't understand a question, please feel free to ask me to clarify. From time to time, your attorney -- are you represented here by counsel today?

A. I am not.

Q. Okay. Well, from time to time today, Miss Courville, who is representing I guess just Duramed but not the witness in the context of this?

MS. COURVILLE: Well, he is an expert that's been retained by Duramed, so that is my relationship with Mr. Bystrom.

MR. EGGERT: Right. Are you representing the witness today?

MS. COURVILLE: Personally? Yes.

MR. EGGERT: Yes?

MS. COURVILLE: Yes.

MR. EGGERT: Okay.

Q. (BY MR. EGGERT) Okay. From time to time,





Miss Courville might object to a question; and if she objects, you can still and should still answer the question unless she directs you not to answer by way of an instruction.

If you need a break at any time or want a drink or something, just let us know and we'll try to accommodate you as soon as we can; and if there's any other questions that come up, just let us know.

A. Okay.

Q. And what was the nature of your testimony in the arbitration against MedImpact?

A. The nature -- I was deposed, and the nature of my testimony, they deposed me to explain my role at Longs and my role at the PBM owned by Longs Drug Stores.

Q. And what was your role at Longs and at the PBM owned by Longs Drug Stores at that time?

A. At that time, I was the vice-president of managed care for Longs Drug Stores and the co-general manager of RxAmerica, and the vice-president of managed care services for Integrated Health Concepts at Longs Drug Stores.

Q. And was RxAmerica the PBM that was owned by Longs Drug Stores?

A. Yes, Longs owned 50 percent of it at that

time.

Q. And -- was it Integrated Health Concepts -- was that also a PBM?

A. It was. The span of the complaint by MedImpact was over a time period during which Longs owned and operated Integrated Health Concepts, which was later merged into RxAmerica. Longs became half owner of RxAmerica, and the complaint by MedImpact spanned that entire period. So I was in those three positions during that time frame.

Q. I see. Let's see. If I could, I'd like to mark as -- oh, boy. Exhibit --

MS. COURVILLE: Oh, that's a tricky one. Should we go off the record and find out?

MR. EGGERT: Want to go off the record for a minute and find out?

MS. COURVILLE: Yes, let's go off the record for a second.

THE VIDEOGRAPHER: We're off the record at 10:07.

(Short break 10:07 to 10:11 a.m.)

THE VIDEOGRAPHER: We are back on the record at 10:11.

(Bystrom Exhibit No. 848 marked for identification.)

Q. (BY MR. EGGERT) Sir, I'd like to show you a





document that has been marked as Exhibit 848 in this case, and it's captioned the expert report of Dale Bystrom, R.Ph. Have you seen this document before?

A. Yes, I have.

Q. And if you turn to page 36 of the document, it's towards the end, is that your signature that appears there dated June 30th, 2002?

A. Yes, it is.

Q. And you have reviewed this document and consider it to be accurate, to the best of your knowledge and belief?

A. Yes.

Q. If I could refer you to attachment A to the document, is this a copy of your CV or curriculum vitae?

A. It is, yes.

Q. And you currently live in Modesto, California; is that correct?

A. That's correct.

Q. Have you always lived in California?

A. No.

Q. During what period of time did you not live in California?

A. 19 -- well, let's see. 1988 through 1989.

Q. And other than that one-year period or one-





to two-year period from 1988 to '89 -- I take it perhaps you were in Illinois during that time?

A. Yes.

Q. Have you lived in California the rest of your life?

A. I have, yes.

Q. Okay. I take it your title, your current title is Director of Business Alliances for Longs Drug Stores; that's correct?

A. That's correct.

Q. And also vice-president of PBM Services for Nex2, Inc.?

A. That has recently changed. Nex2, Inc., has -- as of yesterday, has been acquired by a company called NGenics (phonetic).

Q. What is -- or what was Nex2, Inc.?

A. Nex2, Inc. was a start-up technology company that obtained and provided personal prescription history to the life insurance industry for the purpose of underwriting.

Q. And how did Nex2 obtain personal prescription history to provide it to the insurance industry?

A. I worked for Nex2 as their vice-president of PBM services and established contracts and a network





of PBMs from which the prescription histories were harvested.

Q. So it was your job to contract with PBMs in order to harvest prescription histories for patients; is that correct?

A. That's correct, yes.

Q. And would you acquire them from PBMs, is that what you would do, pay them money, and then they would give you the information?

A. No, what we did was to set up technology at the PBM sites that would allow direct queries from the insurance underwriters to the PBMs to harvest and obtain that information.

Q. I see. So there would be a direct link between the insurers and the PBMs?

A. More indirect, I suppose. The insurance inquiry came to Nex2 and then was distributed out to our PBM network. The responses and prescription profiles were then brought back to Nex2 and transmitted back to the requestor.

Q. Were there privacy concerns associated with this enterprise?

A. Absolutely, yes.

Q. But was there a requirement that the patient or the person applying for insurance had to consent to

this process before it would be undergone?
A. Yes.
Q. And were you an owner of Nex2?
A. I was a shareholder.
Q. Okay. Was -- was Nex2 connected in any way to Longs Drug Stores?
A. No.
Q. Okay. So you held two different positions simultaneously, one for Longs Drug Stores and one for another entity?
A. That's correct.
Q. Are you working part time for Longs Drug Stores during that time?
A. Yes.
Q. How long have you been working part time for Longs Drug Stores?
A. Approximately two years, two and a half.
Q. And how did you split your time during that time period?
A. Roughly fifty-fifty.
Q. Now, what is Longs Drug Stores?
A. Longs Drug Stores is a publicly held corporation of 430-plus chain pharmacies operating in the western United States, California, Hawaii, Oregon, Washington, Nevada and Colorado.





Q. Are most of the stores in California?
A. The largest percentage of the stores are in California, correct.
Q. And Longs Drug Stores operates as a pharmacy?
A. It operates as a retail pharmacy chain, correct.
Q. What were your duties as the director of business alliances of Longs Drug Stores?
A. Director of business alliances, I worked with clients and health plans with which Longs had involvement to develop Internet alliances and business projects that allowed Longs to build their market share of the health plan membership and their pharmacy services, so basically created Internet alliances and in-store marketing programs directly to the clients through the alliances that were created.
Q. Who were the clients that you're speaking of?
A. Clients would be entities like Sharp Health Plan in San Diego; US Script, which was a PBM in Fresno; a number of other PBMs and health plans. We were just beginning this process.
Q. And the idea was to -- was to increase the number of PBMs that Longs Drug Stores dealt with; is





that accurate?
A. That's not accurate. The idea was to create additional business links between existing partners that Longs already dealt with to encourage their patients to use more of Longs services, specifically pharmacy services that were offered through our Internet that I developed for Longs through our website, and to encourage their members to go to our website and use our services for ordering their prescriptions.
Q. So Longs had a mail order enterprise that one could access through the Internet; is that correct?
A. Longs had -- one of their pharmacies located in Dublin, California, would have the capability of mailing prescriptions to individuals. Individuals could also place their prescription orders through our website and have that order directed to the store of their choice of Longs to go pick it up. So they had two avenues with which to obtain their services.
Q. If products were mailed, were they -- were they cheaper than if you bought them directly from the pharmacy?
A. All of Longs programs through the Internet were retail programs. They were not mail service





benefits.
Q. We're okay?
(Alarm is heard.)
MR. EGGERT: We are having a fire drill, but we don't have to participate. Well, we may have to break. Let's go off the record while the --
THE VIDEOGRAPHER: We're off the record at 10:19.
(Short break 10:19 to 19:21 a.m. Steve Michael replaced Scott Michael as the videographer for the remainder of the deposition.)
THE VIDEOGRAPHER: We're back on the record at 10:21 a.m.
Q. (BY MR. EGGERT) Sir, let's see. We're back on the record. In the course of your duties as director of business alliances, did you have -- did you have any responsibility with respect to RxAmerica?
A. I was on the operating committee for RxAmerica.
Q. What is the operating committee for RxAmerica?
A. The operating committee was an oversight board very much like a board of directors.
Q. And so what sort of issues would the oversight board deal with?

A. We dealt with issues such as strategic planning, quarterly review, major performance issues, things like that.

Q. Would you have dealt with managed care contracting issues?

A. Not as a member of the operating committee.

Q. All right. At any time -- at any time after you left the position of general manager of RxAmerica in 1999, were you involved in those type of contracting issues?

A. Not directly, no.

Q. Let's see, between 1997 and 1999, you served as the general manager for RxAmerica; is that correct?

A. Yes.

Q. And RxAmerica was at that time owned by Long Drug Stores; is that correct?

A. Longs Drug Stores, and it started out American Drug Stores, and then they were acquired by Albertson's.

Q. And during the entirety of that time, you were working with RxAmerica?

A. Yes.

Q. What were your duties as the general manager of RxAmerica?

A. My duties were to generally oversee the





operations of the PBM and represent Longs' interest and presence at the PBM location.

Q. Was being general manager kind of like being president, is that a similar title?

A. That was the highest position at the operation, correct.

Q. So if they ask who runs RxAmerica, it would have been yourself?

A. Correct.

Q. Were you involved in managed care contracting decisions at that time?

A. I was involved in an oversight capacity and aware of what was going on in that area.

Q. What is a PBM?

A. PBM is an acronym for Pharmacy Benefit Management. It's a unique entity that is formed to manage the administration of pharmacy benefits between the provider of the benefits, the pharmacy, and the payor of the benefits, be it a health plan or an employer group, municipality or governmental organization. They're an intermediary that provides administrative as well as clinical services to administer the pharmacy benefits for the payor.

Q. What sort of administrative services would a PBM provide?





A. It would provide a number of services, such as management of health plan member eligibility. They provide pharmacy network services, providing networks to pharmacies for the client for the members to access prescription services. The administrative services may cover mail service operations; reporting back to the client, both financial as well as utilization reporting; development of formularies; administration of rebate financials.

And then in addition to the administrative functions, there's a number of clinical functions that may be performed as well, such as compliance programs, refill reminders, disease management programs, drug utilization review programs, to assure that the pharmaceutical therapy was being appropriately distributed and utilized and reported back to the providers and the payors.

Q. So in that way to provide a check on the physicians to make sure that they were appropriately prescribing medications?

A. They call it profiling; yes, to report on the prescribing habits of the physicians.

Q. Let's see. Do you consider PBMs to be interfering in the practice of medicine?

A. No, I think PBMs probably are additive to





that practice.

Q. In what way?

A. Well, in the development of formularies to help determine appropriate and cost-effective prescribing choices; in drug utilization review programs, to assure that there's not duplicate therapy or fraudulent therapy; in the area of administering drug supplies, to make sure there's not overutilization or underutilization.

So I think there's a number of checks they do for safety as well as cost-effective pharmacy therapy administration.

Q. Why would it be necessary for PBMs to set up formularies to ensure appropriate and cost-effective drug administration? Why can't we count on physicians to do that?

A. The physicians don't have a broad-based knowledge of all the pharmaceutical products that are available, nor do they enter into relationships to develop formularies with the drug manufacturers today.

Q. Now, while you were general manager, did you have other people reporting to you who were responsible for managed care contracting?

A. Yes, uh-huh.

Q. And who was that?

A. Our managed care contracting was done by a gentleman named Joe LaPine.
Q. And you considered him to be competent at his job?
A. Yes.
Q. And did you also have a -- what's known as a P & T committee while you were at RxAmerica?
A. We did. We have a pharmacy therapeutics committee that was comprised of physicians in the -- in the area.
Q. What was the role of the P & T committee?
A. The role of the P & T committee was to review formulary selection, formulary choices, and to approve formulary drugs to be placed on formulary.
Q. Would they engage in clinical reviews of the drugs?
A. Yes, they would.
Q. Was that an important role that they performed?
A. That was their major role as -- on the P & T committee.
Q. Let's see. Prior to the time that you were the general manager at RxAmerica, you were the vice-president of managed care services at a PBM known as Integrated Health Concepts; is that correct?





A. That's correct.
Q. And that was between 1995 and 1997?
A. Yes.
Q. And was Integrated Health Concepts a PBM that was a subsidiary of Longs Drug Stores that was later folded into RxAmerica?
A. Yes, it was later merged into RxAmerica.
Q. What were your duties as the vice-president of managed care services at Integrated Health Concepts?
A. I developed -- created Integrated Health Concepts for Longs Drug Stores and was responsible for its oversight as the highest-ranking person within the organization.
Q. Was -- was the development of Integrated Health Concepts as a PBM owned by Longs Drug Stores your idea?
A. Basically my idea, yes.
Q. Why was it that you considered it to be a wise thing to do for Longs Drug Stores to develop its own PBM subsidiary?
A. Prior to my role in developing Integrated Health Concepts, I was responsible for Longs third-party administration and contracting in the managed-care industry. We had a number of groups,





employer groups, municipalities, contact Longs, contact me, to see if Longs was capable of providing a prescription benefit for them; and because of those type of requests, it made sense to me that we wanted to have a more formalized process to do that. And it also made sense that we may be able to improve Longs' market share by being the PBM for clients in our market area.
Q. How would it be that you would improve Longs' market share, I take it vis-a-vis other retail pharmacies, by being the PBM for health plans in your area?
A. By having Longs be the selected, preferred or one of the few pharmacy chains in the network that we offered to clients to utilize.
Q. So as a PBM, Integrated Health Concepts would select certain pharmacies as being preferred pharmacies?
A. We would develop pharmacy networks at the request of the client that would be anywhere from some to all pharmacies, depending upon what the client's needs were.
Q. In what circumstances would you develop preferred pharmacies and what would that mean?
A. Well, one example would be we were requested





to put together a pharmacy benefit program for Gallo health plans, which is Gallo Winery of -- they are located in Modesto, California; and it was their request that only pharmacy providers that purchase their -- purchase and sell their products would be included in their pharmacy network. That's one example of a restricted network.
Q. And Longs Drug Stores sold Gallo products?
A. Yes.
Q. Are there other examples as well that you recall, or was that the only one?
A. There -- we had a pharmacy network we developed for Omni Health Plan to manage their Medicaid program, and that was comprised of Longs Drug Stores plus independent pharmacies in the Omni area. Not -- did not have other chain pharmacies involved in the network. That was another example.
Q. And is that because Longs Drug Stores agreed to give lower prices with respect to those products?
A. It was to enable Longs to have better control over the pharmacy services delivered; that was a reflection on the pricing of those services for the client.
Q. Were you responsible for managed care contracting during the time that you were

vice-president of managed care services at Integrated Health Concepts?

A. Could you repeat that question?

Q. Were you responsible -- were you responsible for contracts entered into between Integrated Health Concepts and pharmaceutical manufacturers at the time that you were the vice-president of managed care services at that organization?

A. Yes.

Q. And would you personally negotiate those agreements with pharmaceutical manufacturers?

A. Yes.

Q. And was it common in connection with those agreements that Integrated Health Concepts would arrange to receive a rebate from a pharmaceutical manufacturer in connection with its agreements with the manufacturer?

A. Let me make sure that I'm not confusing you with my answer. We had relationships with manufacturers for clinical service programs that I negotiated directly with the manufacturers. We also had contracts for formulary rebates which we obtained from another PBM, using their formulary and their contracting process.

Q. What -- what PBM did you obtain the rebate





contracts from?

A. We utilized PBM in Sacramento called PCN, Pharmaceutical Care Network.

Q. So the effect of this using theirs was that PCN would be negotiating rebates with manufacturers on behalf of Integrated Health Concepts?

A. Well, it goes a step beyond that. PCN was utilizing the formulary of Integrated Pharmaceutical Services owned by Foundation Health Plan. They were the contracting entity direct with the manufacturers.

Q. So in essence, is it accurate, then, that Integrated Health Concepts utilized the formularies and the rebate systems that IPS had established with pharmaceutical manufacturers?

A. Through PCN, correct.

Q. And that was true from 1995 to 1997; that's correct?

A. Yes.

Q. As of 1997, did RxAmerica then begin to negotiate agreements directly with manufacturers itself?

A. When the two entities were merged, the health -- the contracts that were -- the client contracts that were owned by Integrated Health Concepts were assigned over to RxAmerica and fell





within their process and their formularies and their rebate administration.

Q. Between 1991 and 1995, you were the director of managed care pharmacy services for Longs Drugs, right?

A. That's correct.

Q. What were your duties as director of managed care pharmacy services?

A. I was in charge of negotiating all of the pharmacy network contracts between Longs Drug Stores and the PBMs and HMOs and anybody else who contracted for pharmacy services with Longs.

Q. Did you have any dealings with pharmaceutical manufacturers in that regard?

A. I was involved with dealings with pharmaceutical manufacturers, yes.

Q. In what sense?

A. We had a -- a drug buyer that met and interfaced regularly with the pharmaceutical manufacturers. When they had programs to offer that impacted delivery of pharmacy services, then I was involved in those discussions as well.

Q. Did Longs Drug Stores often purchase -- purchase drugs directly from pharmaceutical manufacturers?





A. Yes.

Q. And sometimes from --

A. Wholesale.

Q. -- distributors, wholesalers?

A. Uh-huh.

Q. Do you know how they purchased Premarin?

A. I don't specifically recall. Probably both ways.

Q. Have you had any conversations with individuals from Longs Drug Stores about the possibility that in connection with this lawsuit, Longs Drug Stores might -- might attempt to secure payments from Wyeth Pharmaceuticals based on an allegation that the prices that Longs Drug Stores has paid for Premarin have been higher than they should have been?

A. No.

Q. But I take it that the majority of your duties as director of managed care pharmacy services were dealing with -- was it with managed care organizations?

A. That's a good term for it. Managed care organizations can be a blanket term for PBMs and HMOs and health plans and employer groups, and I interfaced with that entire industry that had relationships with

Longs Drug Stores.

Q. And much of what you did was to negotiate the reimbursement rates at which the managed care organizations, which I'll call MCOs, would reimburse Longs Drug Stores in connection with the sales of pharmaceuticals out of Longs Drug Stores?

A. That was a big piece of my job, together with monitoring the performance and regular review with those payors.

Q. Let's see. Prior to 1991, you were the vice-president of marketing at an organization known as American Drug Stores in Oakbrook, Illinois. What were your duties there with American Drug Stores?

A. American Drug Stores, when I came on board with them, was known as American Stores. They were a national pharmacy chain and drug -- drug/supermarket combo operation. It was their intent to divide the company into an eastern and western division and have a western drug chain separate from the eastern -- eastern drug chain; and I was hired to put together the merchandising and marketing programs for the newly developed western drug chain.

Q. And did that end up happening; did they develop a western drug chain?

A. They did not.





Q. Is that why you left them in 1990?

A. Yes.

Q. It didn't pan out?

A. Correct.

Q. But during that period of time, you worked with them not in the western United States, but in Oakbrook, Illinois?

A. The corporate office was located in Oakbrook, yes.

Q. Did you maintain your residence in California during that time?

A. I did the first year. The second year, I moved to Oakbrook -- to Illinois.

Q. In connection with your duties at American Drug Stores, did you have dealings with managed care?

A. I did not.

Q. And then prior to your departure to work for American Drug Stores -- incidentally, is American Drug Stores connected in any way to RxAmerica?

A. American Drug Stores initially developed RxAmerica.

Q. So was your connection with American Drug Stores important in some way to the ultimate merger between Integrated Health Concepts and RxAmerica?

A. It was in the fact that I knew the





organization and the people involved and did the negotiation for Longs in putting that merger together.

Q. And why did you consider it to be to Longs' advantage to facilitate a merger with RxAmerica rather than to just continue along with Integrated Health Concepts as a freestanding PBM?

A. Longs Drug Stores' market penetration in California is primarily northern California, from Bakersfield north. The stores that American Drug Stores owned in California, the Savon stores, were primarily southern California. It was the feeling of both Longs and American Drug Stores that as opposed to one chain buying the other, which was an expensive proposition, they might be able to achieve economies of scale by having a mutually owned PBM that could offer that chain network to providers in California.

Q. So it was largely a California-driven merger?

A. It was driven by events that were occurring in California and also consolidation events that were occurring within the industry, the PBM industry.

Q. Would it be fair to say that California is a -- a leading or cutting edge state in connection with managed care in the PBM industry?

A. Yes.





Q. And is the prevalence of managed care greater in California than in other areas across the country?

A. Generally speaking, I believe it is.

Q. Let's see. Prior to your departure, you worked as the general merchandise manager for Longs Drug Stores in Walnut Creek, California. What were your duties between 1986 and 1988 in that position?

A. Walnut Creek, California, is where Longs' corporate office is located, and my functions in that capacity were to oversee the merchandise acquisition and advertising for -- the general merchandise acquisition and promotion for Longs Drug Stores.

Q. Would that have involved acquisition of pharmaceutical products?

A. Not legend drug products. Over-the-counter products, but not legend -- not prescription, legend drug products.

Q. A legend drug product is the same as a prescription drug product?

A. Yes.

Q. Between 1980 and '86, you were a store manager. Was that a store manager for one particular Longs drug pharmacy?

A. Yes.

Q. And that was located in Modesto, California?
A. Yes.
Q. What were your duties as a store manager?
A. My duties were to oversee the entire store, hire personnel, do the advertising and basically run the store.
Q. Did you have responsibilities related to the acquisition of pharmaceuticals or was that handled by Longs' central offices?
A. Both. The Longs stores have the autonomy to buy directly from -- at store level as well as buy through the Longs central distribution facility. So there was some of both taking place.
Q. Did you have any dealings with Wyeth-Ayerst in connection with your duties as a store manager?
A. I don't think so. I don't recall having direct -- direct relationships with Wyeth-Ayerst as a store manager.
Q. I see. Prior to being a store manager, you were a pharmacy manager -- it was at a Longs Drug Store in Carmel, California, correct?
A. Correct.
Q. What were your duties as a pharmacy manager?
A. I was in charge of running the pharmacy for Longs at the Carmel operation and overseeing the





pharmacy staff in that store.
Q. Were you acting as a pharmacist?
A. Yes.
Q. And how big was your staff?
A. Had two staff pharmacists and I believe we had three ancillary non-pharmacy personnel in addition to the staff pharmacists.
Q. Now at the time that you were a pharmacy manager between 1970 and 1979, managed care was not a major force yet; is that correct?
A. That's correct.
Q. Were there such things as PBMs at that time?
A. Yes, there were.
Q. Who were the PBMs that you dealt with?
A. The ones that come to mind that we dealt with, Paid Prescriptions, who is now Medco, PCS. Those are the two major PBMs that were there. There's probably others; I just don't recall who they were at that early time in the industry.
Q. And then from 1968 to '69, you were a staff pharmacist. What were your duties as a staff pharmacist?
A. Just to fill prescriptions and professional responsibility behind the counter.
Q. The type of computerized system linking up





with PBMs that you describe in your report was not in existence at that time, was it?
A. Longs I believe got into computerizing their pharmacies in the early '80's.
Q. So about 15 years or so after you had served as a staff pharmacist?
A. Correct.
Q. Let's see. You graduated from the University of the Pacific School of Pharmacy in 1968, correct?
A. Yes.
Q. Is that an undergraduate degree?
A. It's a Bachelor of Science in Pharmacy degree.
Q. Okay. Have you obtained any other degrees other than your B.S. degree in pharmacy?
A. I have not.
Q. Okay. Did you go to a -- is the University of the Pacific School of Pharmacy, is it devoted entirely to pharmacy?
A. It is, yes.
Q. How many years of study does one have to take or did you have to take to get a B.S. degree in pharmacy?
A. Mine was a five-year program.





Q. And that would have been five years after graduation --
A. After high school, yes.
Q. -- high school?
A. Yes, uh-huh.
Q. Is that also like a liberal arts type of school or is it just devoted exclusively to learning about pharmacy?
A. No, they've got several schools of -- they've got liberal arts and a couple of other schools on that campus. After I graduated, they developed a separate campus for the pharmacy school adjacent to the University of the Pacific.
Q. Where was the School of Pharmacy located?
A. It was located in the science wing, science building on campus.
Q. And what city is that located?
A. Stockton, California.
Q. Let's see. Have you ever -- you also I guess engaged in the Kellogg Executive Programs at Northwestern University?
A. I attended two of those, yes.
Q. What are those?
A. Those are business development programs focused in managed care negotiations and negotiations

in general.
Q. So that was specialized training in how to negotiate in the managed care context?
A. In the -- in the managed care environment, yes.
Q. And did you attain any degrees or --
A. A certificate.
Q. Certificate?
A. Certificate of attendance.
Q. Have you obtained any degrees -- maybe I already asked you this, but any degrees at all other than your B.S. degree in pharmacy?
A. I have not.
Q. Do you have any training in economics?
A. Just the economics class I took in college.
Q. How about -- let's see. You've never worked for a pharmaceutical manufacturer, have you?
A. Correct.
Q. And do you have training in -- in marketing?
A. Hands-on training.
Q. Any educational training in the area of marketing?
A. No formalized training.
Q. Let's see. I notice under your professional activities, you're a member of a number of





organizations. What is the American Managed Care Pharmacy Association?
A. American Managed Care Pharmacy Association is an association of pharmacists involved in managed care. It also has PBMs and mail service organizations involved with it.
Q. Are manufacturers also involved?
A. I don't know the answer to that, if their membership -- if they have membership or not.
Q. Have you ever held any offices in the American Managed Care Pharmacy Association?
A. No.
Q. Have you ever held any offices in any of the professional organizations listed on your CV?
A. No.
Q. Do you have any publications in the area of pharmaceutical science?
A. No, I don't.
Q. Any publications at all?
A. No.
Q. In anything?
A. No.
Q. And have you ever conducted any peer-reviewed work in the areas of pharmaceutical science?
A. I was involved in the State of California





Medicaid Peer Review Committee back when I was in the pharmacy area of my career.
Q. And were you reviewing other persons' work or was your work being reviewed?
A. Other persons' work.
Q. You list on page 2 of your resume industry advisory panel participation. What does that mean? What is industry panel participation?
A. There was several health plans that had pharmacy advisory panels that they would meet on a quarterly basis to discuss the pharmacy component of their health care plan and how it relates to retail pharmacy on an advisory basis. We usually met quarterly.
Q. And you would meet and then advise persons associated with the organization?
A. We would provide them input as to their -- how their program was working; or if they had new initiatives they wanted to develop, they would use our committee to develop those -- get input to develop those initiatives.
Q. And you worked for various drug companies in that regard, Parke-Davis, Warner Lambert, Merck and Lilly, right?
A. Right.





Q. As well as Astra.
In connection with that, did you ever consult with any managed care organization concerning the use of market-share incentive rebate agreements or exclusivity arrangements in the managed care arena?
A. Not that I can recall.
Q. That issue never came up, as far as you know?
A. No.
Q. What sort of things did you consult with with the drug company?
A. On their advisory committees?
Q. Yes.
A. Provided input, again, representing the pharmacy industry, for some of their new initiatives, concepts, drugs they were bringing to market, how they should bring them to market, and just provide feedback and expert opinion on how their performance could best be applied in the retail pharmacy industry.
Q. And did you consult with the pharmaceutical manufacturers in any capacity other than in connection with the industry advisory panel?
A. No.
Q. What sort of consulting work did you do at Harvard Pilgrim of Boston, Massachusetts?

A. Harvard Pilgrim, I did consulting work with them in my capacity as vice-president of PBM networks when I worked -- was working with Nex2; and it had to do with obtaining prescription profile history for research that they were interested in.

Q. Let's see. Now, you've never previously been certified as an expert witness in any case, have you?

A. That's right.

Q. What is it you would consider to be your area of expertise?

A. Retail pharmacy and PBM industry.

Q. Retail pharmacy and the PBM industry?

A. Correct.

Q. And that's based on your hands-on experience in that area?

A. Yes.

Q. Your experience in that area has occurred primarily in the state of California; is that correct?

A. In the retail pharmacy area or the PBM area? Which one are you referring to.

Q. Let's take them separately. In the retail pharmacy area, has your experience been primarily in the state of California?

A. As a pharmacist, it has been. As the





vice-president of managed care services, it spanned all six states in which Longs operated.

Q. So those six western states that you mentioned earlier?

A. Yes.

Q. And how about in the managed care arena?

A. It was national, the managed care arena. We were located in Salt Lake City, Utah, but our contracts were national in scope.

Q. So RxAmerica had contacts across the country?

A. Yes.

Q. Let's see. If I could ask you to turn to your report. Incidentally, did you -- did you write the first draft of this report?

A. Yes.

Q. And did anyone assist you in writing the report?

A. No.

Q. So you didn't have any other assistance or other persons working with you. Did you type it yourself?

A. Yes.

Q. Without -- without disclosing any conversations with counsel, did you have input from





counsel for Duramed in connection with preparation of the report?

A. Yes.

Q. Did you have any communications with anybody from Duramed about the report or in preparation of your writing of the report?

A. No.

Q. So you've never talked to anybody from Duramed?

A. In preparation of this report, that's correct.

Q. Have you talked with anyone from Duramed in any other context?

A. Not that I recall.

Q. How about with Viking Health Care? Are you familiar with an organization known as Viking Health Care?

A. Vaguely familiar with them.

Q. Do you consider them to be competent managed care specialists?

A. I'm not qualified to comment on that. I'm not that knowledgeable about them.

Q. You've never had any direct dealings with them?

A. Correct.





Q. Did you have any communications with anybody from Viking before rendering the opinions in your report?

A. No.

Q. How about anyone from Solvay Pharmaceuticals?

A. No.

Q. Did you actually -- did you interview anybody or talk to anybody before reaching the views in this report?

A. No.

Q. Did you reach your views, then, entirely upon reading certain documents?

A. Upon -- based upon my industry experience and reading documents, correct.

Q. What documents did you review?

A. I reviewed a number of documents that were provided by Duramed through Susman, a number of which are referenced in the report; and I reviewed a number of industry documents which are also referenced in the report.

Q. Did you review any depositions?

A. There were a couple of depositions I looked through.

Q. Whose depositions were those?

A. You know, I'm not sure I recall. I've read so many documents and seen so many names now. Carter, I think was one. Was there a Marty Carter? Might have been one, and a Finneran, Finneran?

Q. Bill Finneran?

A. Bill Finneran, that sounds like a familiar name.

Q. Do you remember who they worked for?

A. Not specifically, no.

Q. Did they work for Wyeth?

A. I believe they -- I believe they worked for Duramed.

Q. And was there anything that you read in those depositions that informed the opinions that you reached in your report?

A. No, they didn't inform my opinions or create my opinions based on those depositions that I read.

Q. Was there anything in those depositions that supported your opinions?

A. They were consistent with my opinions, yeah.

Q. Do you remember what in particular about Mr. Carter's deposition was consistent with the opinions rendered in your report?

A. No, I don't.





Q. Do you remember anything in particular in Mr. Finneran's deposition that was consistent with any of the views expressed in your report?

A. No, I don't recall specifically.

Q. Okay. If I could, I'd like to walk through a little bit of the report.

Before I do that, though, how many hours have you -- did you work on this case prior to the preparation or in connection with the preparation of your report?

A. Let me try and recollect. I don't have an exact tally of the hours. Probably somewhere between fifty and a hundred hours. That's just as best as I can recall.

Q. And you're being compensated at a rate of $300 an hour?

A. Correct.

Q. So have you been paid something in the neighborhood of say $15 to $30,000 by Mr. Susman's law firm?

A. That would be correct.

Q. How much are you being paid for your testimony here today?

A. 300 -- the rate of $300 per hour.

Q. Still 300 an hour? Is that your normal





consulting rate?

A. For being an expert witness, it is.

Q. You indicate, for example, that you've consulted for several different companies nationally within the health care industry, also. Is $300 your consulting rate in that connection?

A. I have had different rates with different companies.

Q. Have you ever commanded a rate as high as $300 per hour before in connection with anything you've ever done?

A. I believe I have before, yes, with a company that I worked with, Nex2, when I initially started with them.

Q. Anyone else?

A. Not that comes to mind.

Q. Let's see. If you can turn to page 5 of your report, under III A, pharmaceutical distribution system, I'm interested in the last paragraph of that section. It indicates that in the last sentence, PBMs act as aggregators of pharmaceutical providers and patients, providing an efficient delivery system for pharmaceutical products and services. What do you mean by that sentence?

A. PBMs enter into contracts with payors, be it





health plans, employer groups or whomever needs to have pharmacy services delivered to a population group of members. And by doing such, they provide aggregated numbers of members to make available to the pharmacy providers when they enter into contracts with the pharmacies so that they provide an efficient delivery system for those members, directing them to those pharmacies and adjudicating their prescription claims through the claims processing services.

Q. So in that sense, you think that PBMs are good for consumers and good for holding down the costs of health care?

A. I think PBMs are a valuable function in the industry as an intermediary between the payor and the provider of services and provide a safeguard for patients receiving pharmaceutical care.

Q. In what way do they provide a safeguard for patients receiving pharmacy care?

A. Well, within their pharmaceutical claims processing system, they have a -- what are called drug utilization edits built in which will review the drugs for a number of conditions, such as, is it the appropriate drug for an individual of that particular age; is the individual taking another drug concurrently that might conflict; is the dosage

appropriate, is it too high, is it too low. There's a number of safety edits that the PBM will perform called drug utilization reviews as well as -- those are done concurrently.

They also have a retrospective drug utilization review to work with the payors and the physicians to ensure that the pharmaceutical therapy is appropriate for their particular disease state and it's being delivered appropriately. So in that sense, I think they add to the care of the individual.

Q. And provide a check on what physicians are doing in prescribing the drugs?

A. They also do the physician profiling and reviewing of their prescribing, yes.

Q. A little bit further down, under the section "payment cycle for pharmaceuticals," you indicate that pharmacy patients can be divided into two categories, cash patients and third-party patients. I take it cash patients are persons who are not insured; is that correct?

A. That's generally correct. They pay cash for their prescriptions.

Q. What percentage of the pharmaceutical marketplace is accounted for by cash payment -- cash patients as opposed to third-party patients?





A. Well, in the industry today, the cash patient percentage of the pharmacy benefit receipts are getting less and less. They're in the 10 percent range now for the majority of the pharmacy providers.

Q. Where were they say in 1999?

A. 1999, they were -- depending upon which -- which group you -- which pharmacy group you are measuring, they could have been as low as 70 percent. Somewhere between 70 and 85 percent.

Q. 70 and 85 percent would have been third-party --

A. Correct.

Q. -- patients?

A. Yes.

Q. And so between 15 and 30 percent would have been cash patients?

A. Correct.

Q. And I take it that formulary decisions by managed care would not have significant impact on the availability of products to cash patients; is that correct?

A. Don't think that's entirely correct. It's been my experience that physicians usually stay within a pretty narrow range of drugs that they offer their patients; and if the bulk of their prescribing





involves patients that are covered by managed care, that small group of drugs are going to be drugs that are on formularies of managed care, and it's very likely they will use those same drugs for all their patients, whether they're cash or third-party.

Q. What's the basis for your experience in that regard?

A. Just in talking with physicians and also monitoring the prescription profiles within Longs Drug Stores, which includes cash as well as third-party. There doesn't seem to be a huge difference in their utilization patterns.

Q. Of course that would be consistent with the possibility that their utilization patterns aren't really affected very much by the formularies in the first instance, right?

A. I wouldn't say that.

Q. It would be consistent with that, wouldn't it?

A. That could be consistent with it, yeah.

Q. And who are the physicians that you've ever spoken to that have indicated to you that they -- that they prescribed the same drugs for patients that are on formularies and those that don't have formularies?

A. I've done a fair amount of work with





Dr. David Gibson in developing electronic prescribing technology devices; and in that capacity, we spent time interviewing and talking with physicians in several medical groups in the California marketplace.

Q. And when did that occur?

A. That occurred between 1999 and probably 2001. Somewhere in that time frame.

Q. And that was, once again, in connection with the California marketplace, right?

A. California and Hawaii.

Q. And you're -- you're aware that Mr. -- or Dr. Gibson has been named as an expert in this case as well?

A. I am.

Q. Are you the one that provided Mr. Susman's firm Mr. Gibson's name?

A. It was the other way around; he provided them my name.

Q. So they got to him first and then they got to you; is that right?

A. Yes.

Q. When you say you and Dr. Gibson talked to a number of physicians during the course of -- what was it you were doing between 1999 and 2001, again? I'm sorry.

A. I was assisting Dr. Gibson in his development of electronic prescribing technology and pilot programs to demonstrate its value and usefulness.

Q. And this would be -- for example, a physician in his or her office would simply put a prescription on line rather than give a slip to a patient to take to a pharmacy; is that what you mean by "electronic prescribing"?

A. It was the development of the hand-held wireless electronic prescribing device much like a PDA in size, through which a doctor could order a prescription and submit it to a pharmacy in a wireless environment.

Q. And in that connection, the two of you talked to a number of physicians?

A. Yes, physicians and physician groups.

Q. And did you specifically raise with those physicians the issue of whether they prescribed the same sort of drugs to cash patients as to insured patients?

A. What we talked about with those physicians was the way that they made selections for their drugs and how they wanted their drugs listed on the prescribing device so they would be drugs they're used





to using for all of their patients, which would keep them on formulary as well as allow them to prescribe it to all their patients.

Q. And did you -- you and Dr. Gibson produce any documents or reports in that regard?

A. No.

Q. So it's all in your heads?

A. I have not produced any reports in that regard.

Q. Do you know if Dr. Gibson did?

A. Don't know if he did or not.

Q. He never wrote anything that he gave to you?

A. I don't recall seeing anything that he's written on that subject.

Q. And what did you find about the factors that doctors look at when they prescribe drugs in connection with that work?

A. Their -- one of their high concerns is whether or not the drug is on formulary for the health plan that the member is enrolled in so they won't have any difficulty getting it prescribed.

What we learned was that a significant amount of the phone calls that are received by the physicians are due to pharmaceutical issues arriving from the prescribing of non-formulary drugs. So they





felt that that type of technology could reduce time spent on those activities by assuring that they were formulary drugs that they were prescribing.

Q. And did you ever implement this electronic prescription technology?

A. We had implemented two pilot programs, one in Santa Barbara, California, and one in Oahu, Hawaii.

Q. And did the pilot programs allow that type of on-line adjudication as to whether or not the claims would be covered by the patient's managed care plan?

A. It did, yes.

Q. And did that result in any change in the prescribing patterns of the physicians in question?

A. It was hard to tell. The pilots didn't run that long.

Q. Would there be data relating to those pilots?

A. There probably is data relating to those pilots. I don't have such data, however.

Q. Does Longs Drug Stores -- would Longs Drug Stores have that data?

A. No.

Q. Who would have the data?

A. If anyone would have the data, Dr. Gibson





would be the primary holder. It was his company that was developing the technology.

Q. What was the name of his company at the time?

A. Rx Physician.com.

Q. Let's see. You say in your next paragraph here that the payment cycle for pharmaceuticals begins at the pharmacy with the patient and/or patient's health plan paying the pharmacy their usual and customary retail price or a negotiated contract price for their prescription. I take it -- would a cash patient pay what you call the usual and customary retail price?

A. Yes.

Q. And what you mean by "the usual and customary retail price," then, is the price that the pharmacy charges for the product for someone that just walks in off the street and wants to buy it?

A. Correct.

Q. And then -- but that's not the price that managed care entities pay, generally; is that correct?

A. They may pay that price.

Q. But they often -- in fact, almost always, negotiate special -- special prices, special negotiated prices, right?

A. Prices that managed care negotiates with retail pharmacy providers has normally several levels involved in it. It's usually a negotiated discount off the cost of the medication plus a dispensing fee or a maximum allowable cost, called MAC, or usual and customary, and it defaults to whichever is less of those three. So in some cases, it's possible that a managed care patient would pay usual and retail, usual and customary retail.

Q. It's fairly rare, though, isn't it, that the usual and customary retail price would actually be less than the negotiated price that the managed care entity has negotiated with the pharmacy?

A. It's not rare when it pertains to generic drugs because of their low cost.

Q. With respect to branded products, it would be more rare?

A. That's correct.

Q. And you indicated that I guess the prices negotiated with managed care entities are based as a percentage off of the -- or percentage of the price of the drug; that's not really accurate, is it? Isn't it generally a percentage off of what's known as AWP?

A. That's the price, the pharmacy AWP price is the one I was referring to.





Q. Right. AWP --

A. Average wholesale price.

Q. AWP is not actually the price that the pharmacy pays, is it?

A. Correct.

Q. Like when Longs buys products, it doesn't pay what's known as the AWP price, generally?

A. Correct.

Q. But it's a --

A. It's an industry benchmark, yeah, it's a benchmark in the industry.

Q. And what is the maximum allowable cost; how do you compute that?

A. Maximum allowable cost is primarily for generic medications. And the reason they have that is because generic medications can be manufactured and/or distributed by a number of different entities that produce the same generic drug and they can apply their own pricing to it. So in order to have some uniformity of pricing for the health plan, they have developed what's called maximum allowable cost lists for generic pharmaceuticals, and those lists are applied in the pricing logic.

Q. Would maximum allowable cost then not generally apply to a product like Premarin or





Cenestin?

A. Correct.

Q. So primarily, we're dealing with either the negotiated price with the MCO or the usual and customary price?

A. When you're referring to branded drugs?

Q. Yes.

A. Yes.

Q. Although in that case, in the vast majority of cases, it's the negotiated price with the MCO that will be lower and thus be applicable, right?

A. Yes. Usually that's true.

Q. Now. Bear with me. I'm going to have a little hypothetical question here; and if you need to jot down a note or something, feel free. But -- so it might be a little bit elaborate in the way that I set it up.

But assume with me for a moment that there's a consumer who has a plan that has a three-tier co-pay. You know what I mean by a three-tier co-pay?

A. Yes.

Q. And assume that with respect to that plan, Premarin is on the second tier, the branded -- the branded tier, branded formulary tier.

A. Okay.





Q. And that Cenestin is on the third tier of that co-pay.

A. Okay.

Q. Assume that the branded co-pay is, say, $20, the second tier co-pay and the third tier co-pay is $35.

If the patient goes into a pharmacy, and that pharmacy has a negotiated price with -- this is a patient that wants to get say Cenestin. If the patient wants to get Cenestin, it's on third tier, he goes into the pharmacy -- I'm trying to figure out what price that patient -- that she would actually pay.

Would she pay the AWP minus "x" percent price that has been negotiated between the pharmacy and that -- and her managed care plan, or would she pay instead the usual and customary price that that pharmacy has for Cenestin, or would she pay the $35 co-pay?

And assume with me for a moment -- I know; I told you it would be a little bit complex -- that the AWP for Cenestin is let's say $25. And if you compute the AWP -- let's suppose that the negotiated price is with the -- with the MCO is AWP minus 10 percent plus say a $2 handling fee. So $25 minus 10

percent would be $22.50, plus a $2 handling fee would be $24.50, would be the negotiated price.

Assume that the usual and customary price for someone that walks in off the street at that pharmacy is $27, that they would mark it up a little bit over AWP, and then the co-pay -- the third-tier co-pay is $35.

So she goes into the store. Does she pay $24.50 for Cenestin, does she pay $27 or does she pay $35?

A. That's a -- depends on a couple of things. Each pharmacy chain -- and I'm going to talk about the chains, because they fill 70 percent of all retail prescriptions, and that's where my background is.

Each pharmacy chain negotiates individually with the payor for their contract to be in the network. Terms of reimbursement are a critical part of that negotiation. It's possible that a pharmacy chain would negotiate reimbursement in a manner by which the patient would always pay their co-pay regardless of usual and customary, regardless of negotiated rate. That's one scenario in which your patient would pay $35.

Q. Even if the product cost $5 in the usual and customary?





A. That's correct. In that case, they could opt out and either pay usual and customary and not buy it on the plan; and what some pharmacy chains have done is to have two usual and customaries, and --

Q. Why would they have two usual and customaries?

A. They would have a usual and customary for managed care patients that would be no less than the managed care co-payment. It's also possible that a pharmacy chain might negotiate with the managed care entity to have payment be the lesser of the patient co-pay or the usual and customary price, in which case they would pay the usual and customary price.

So there's not one blanket rule that would apply across the industry on that. It depends on how the chain has negotiated their reimbursement with the managed care organization.

Q. And it's also possible that a managed care entity would negotiate with the pharmacy so that the -- that the customer, the consumer, would get the benefit of the negotiated price?

A. That's absolutely correct. That could occur as well.

Q. How did that most often occur in the context of RxAmerica?





A. In the context of RxAmerica, we most often required the co-pay or the usual and customary amount.

Q. Either the co-pay or the -- so that, for example, if -- but when a consumer went in, say, and was faced with say a $35 co-pay for a third-tier co-pay, and in this case, the shelf price of the product say was $27 for someone that just walked off the street --

A. Uh-huh.

Q. -- she could simply buy it not on the health plan, but just buy it out of her pocket for $27?

A. Let me make sure I understand which case we're talking about. In the case of RxAmerica, the patient would be charged the pharmacy's usual and customary rate of $27 when she bought it on the health plan or if she bought it off the health plan as a usual and customary patient.

Q. She would pay $27 either way?

A. In that scenario, yes.

Q. So what RxAmerica would do would be the lesser of usual and customary or the co-pay, is how much she would pay?

A. Correct, correct.

Q. And are you familiar with other managed care





plans that actually enabled the consumer to get the benefit of the negotiated price that the MCO had negotiated with the pharmacy?

A. It's my opinion that most payors will negotiate with pharmacy providers in a way that will -- they have what's called a -- I believe they call it a zero co-pay logic; and what that means is that the patient will pay either their co-pay or the usual and customary price, but the price will never default below those two, to a calculated price.

Q. And why would the MCO take that position rather than trying to stand up for the woman who's purchasing the drugs in this case to get her a lower price that would be consistent with the negotiated price?

A. The pharmacies are -- over the past ten to fifteen years, managed care negotiations have continued to drive profit margins in pharmacies lower and lower. Consequently, pharmacies will hold onto whatever piece of profit they can. And that's a significant chunk of profit that they would be giving up if they were to accept less than that, less than their usual and customary rate.

Q. And it's not one that's quite so valuable to the PBM since the money is coming out of the

customer's pocket and not the PBM's pocket, right?
A. It's a price that's totally invisible to the customer, so that's correct.
Q. It's invisible to the customer only to the extent that the customer doesn't know that she is getting the negotiated price that her managed care organization negotiated with the pharmacy, right?
A. Correct.
Q. Let's see. If you can turn to page 6 of your report, you're talking about rebates that a drug manufacturer pays back to a PBM. In your experience, it's quite frequent, is it not, for manufacturers to pay a percentage of rebate back to PBMs for specific drugs dispensed to their members on the PBM's formulary?
A. That's correct.
Q. And most commonly in the industry, the PBM will share some or all of that rebate with its client health care plans, right?
A. That would be correct.
Q. And to that extent, then, these rebates --
A. Let me -- let me just qualify that to say that situations do exist where those rebates are not shared back to the payor as well; but as you stated, most commonly there is some sharing that goes on.





Q. And when rebates are extended down to the client plans, in that sense, they lower the cost of providing health care by those plans, right?
A. That's true in some of the cases. That's not always true in all of the cases. And the mechanics of the rebate distribution back to the client usually is a protracted time process. It takes anywhere from 60 to 90 to 120 to 180 days to get all of those dollars back for the quarter in which the activity occurred, which makes it difficult for some plans to budget accurately against that. And some plans simply take that money in and don't apply it against their pharmaceutical care budget for that reason. Some plans do, in fact, budget against that in their negotiations and account for a credit of some type for a rebate when they're negotiating.
Q. And even if it's delayed, they do eventually get the money, right?
A. Eventually, they'll get whatever is due to them. Let -- lowering the cost of health care is the intent of the formulary, one of the intents of the formulary, to provide cost-effective health care. There are situations, however, that I have seen where formularies are created to drive rebates rather than to drive low net -- low net costs of products; and in





that situation, a formulary could actually be listing preferred drugs that are higher cost in order to receive a higher rebate for their client, in which case the health care ends up being higher cost health care. So I've seen that done as well.
Q. Now, why would that be advantageous to the client? The client ends up paying more for the drugs, but gets a higher rebate? Why would that be advantageous to the client?
A. Depends upon how the client is being reviewed and incentivized for their budgeting and how they deal with the rebate. It certainly would be advantageous to the PBM involved because they would receive a higher rebate.
Q. To the extent that they weren't passing it through to the client?
A. Whatever percentage they were keeping would be higher as a dollar figure even if they were passing the remainder through, that's correct.
Q. All right. So to a certain extent, you're saying there's a conflict of interest, then, between the clients and the PBM's on this issue?
A. That might exist in some case, that's correct.
Q. Did RxAmerica do that frequently, did they





charge higher rebates so their clients would pay higher amounts of money?
A. RxAmerica doesn't charge rebates, number one; RxAmerica's formulary was developed and based on the lowest AWP approach regardless of rebates, and then whatever rebates were applied were applied after that.
Q. But they kept rebates; they kept a portion of the rebates, correct?
A. That's correct, yes.
Q. And did they try to jigger their contracts with pharmaceutical manufacturers to get big rebates at the expense of their client plans so their client plans would pay more for drugs?
A. No, I -- what I just explained was, their formulary was driven by low AWP-price drugs. So the rebates were applied on those drugs rather than selecting the highest-cost drugs as your preferred items in each category.
Q. Now, would you say that the PBM industry is competitive?
A. It is, yes.
Q. And PBMs compete with one another for the business of client plans, right?
A. Correct.

Q. And to the extent that a PBM is screwing over a client plan by trying to get big rebates for itself at the expense of its client, that would, if discovered --

(Reporter asks for repeat.)

Q. -- that would redound to its detriment in connection with competition with other PBMs for that client's business?

A. That was a question I -- you kind of lost me on that one as well. But let me answer what I think I heard.

It's possible that a client would be more interested in receiving high rebate payments or even up-front payment guarantees based on future rebates to enter into a contract with an entity that makes that offering as opposed to entering into a contract that had lower acquisition costs from day one as opposed to receiving the generous up-front rebate guarantee from a PBM. I've seen that happen.

Q. All right. The rebate guarantees, they're not generally guaranteed, are they; they're based upon the performance of the drug and the -- and the managed care plan's sales, right?

A. It's not uncommon to guarantee a rebate back in terms of a flat dollar amount per claim. I've seen





that done in the industry as well.

Q. Is it part of the contentions of this case that Wyeth has done that?

A. I didn't comment on that in this particular case.

Q. So you have no opinion on that?

A. That's correct.

Let me make one more comment regarding that.

Q. Yes.

A. This case involves Wyeth working with the PBMs. The situation that we just referred to was the PBMs working with the payors in their negotiations together.

Q. Right. In terms of passing through the rebates that the manufacturers have provided --

A. Correct.

Q. -- to the PBM?

A. Correct.

Q. PBMs are also compensated in part through the use of administration fees, right?

A. That's correct.

Q. Is there anything wrong with that, in your view?

A. It's common in the industry.





Q. RxAmerica took administration fees, right?

A. Correct. There's costs involved to the PBM to administer the rebate mechanics, so it's not unusual to have a service fee or administration fee involved there.

Q. Would you agree that one way that the PBMs compete against one another is in the extent to which they pass on manufacturer rebates to their client plans?

A. I think that's probably -- that could be true to an extent. In the negotiation process, the process can occur either as a low-cost program due to controls on drug utilization that results in lower-cost drugs being prescribed and lower cost to the health plan as a result of that. That's one way to lower a client's cost.

Another way is to obtain large rebates and apply those rebates back to the client, is another way to lower costs. So there's different ways of presenting an offer in response to a request for a proposal from a client.

Q. But one of those ways would be to pass through large amounts of rebates down to the client?

A. Correct.

Q. If you turn to page 7. Let's see. You say





at the point of service in a retail pharmacy, when a patient receives their prescription, they pay 100 percent of their prescription cost if they are a cash patient, or if they are a third-party patient, they pay a portion of their prescription cost, the co-payment, with the remainder of the cost billed to the health plan that subsequently pays the pharmacy. That sets forth the usual scenario, right?

A. Yes.

Q. Although as we did discuss earlier, the -- if, in fact, the usual and customary charge is lower than the co-payment, then the patient would pay only the usual and customary in most cases, right?

A. Correct.

Q. And in that case, there would be no -- no compensation that would flow from the PBM to the pharmacy, right?

A. There would be a zero billed receivable on the program.

Q. Okay.

A. Could we take about five minutes?

Q. Sure. We've been going for a while. I was going to suggest the same thing myself.

A. Thank you.

THE VIDEOGRAPHER: We're off the record

at 11:36.

(Short break 11:36 to 11:45 a.m.)

THE VIDEOGRAPHER: We're back on the record at 11:45.

Q. (BY MR. EGGERT) Sir, if I could direct your attention to page 8 of your report in the third paragraph under -- under Roman IV, the last sentence there states that clinical services range from formulary management to sophisticated disease management programs. What exactly is formulary management?

A. Formulary management would involve review of formulary compliance. For example, let me just share with you what happens in the PBM retail setting. PBMs such as Medco, Express Scripts, AdvancePCS, most all of the major PBMs, as well as several of the major health plans that perform their own PBM functions, regularly review with their pharmacy providers, usually on a quarterly basis, their compliance in generic fill rate, how high their generic substitution rate is: for example, out of 1,000 prescriptions filled, were you filling 500 of them generically; were you maximizing the opportunity to use a generic whenever possible. That's important to the health plan. They monitor and they measure that.





And there's often times financial incentives or disincentives tied to generic fill-rate percentage by the PBM or the pharmacy provider. Likewise, they also monitor the degree of formulary compliance that a pharmacy provider dispenses. And some pharmacy contracts with payors have credentialing requirements, some of which are generic fill-rate targets and formulary compliance targets.

So that's what the formulary management process consists of in the PBM perspective; and like I mentioned, there's often time financial incentives or disincentives tied to formulary compliance for a retail pharmacy in their contract and/or generic fill rate.

Q. Now, what's the basis for your knowledge of what a PBM like Medco or AdvancePCS or Express Scripts does in this regard? I take it you worked for RxAmerica, right?

A. My knowledge with them doing that is based on my negotiating those contracts with them for Longs Drug Stores.

Q. I see. So this was based on -- at least this is the way that they dealt with these things in connection with their negotiations with Longs Drug Stores?





A. Correct. And other chains.

Q. Do you know how they dealt with other chains?

A. In exactly the same fashion, because they would benchmark chains against each other for performance and use that as a demonstration of what could be done.

Q. So that's how --

(Reporter asks for repeat.)

Q. So that's how they would deal with the chain drug stores, to your knowledge?

A. Correct. Yes.

Q. We have to talk separately or else we confuse the reporter.

Let's see. Two paragraphs down, you state that PBM services revolve around the drug benefit designed by the client. The benefit design determines the therapeutic categories of drugs that are covered including whether cosmetic, life-style and over-the-counter drugs are reimbursed, and the extent to which generics and formulary drugs are mandated. Who is it that determines the benefit design?

A. That's normally done in a collaborative fashion between the PBM and the client. The client, depending upon their level of sophistication, may have





specific components they want in their drug benefit, or they may simply ask the PBM to bring them a drug benefit design that's common to others in the industry.

Q. So many MCOs design their own benefit design; is that right?

A. Some of the larger payors design their own drug benefit design, correct. It's not uncommon for larger payors, like Blue Shield of California, to assume many of the PBM functions and contract out for some of the administrative functions to the service what they've assumed internally. So they may contract out for claims processing, but negotiate their own pharmacy networks and develop their own plan design.

A smaller client doesn't have the sophistication to do that; he usually relies on the PBM for assistance in that area.

Q. Right. Do you know of any circumstances in which it's Wyeth that's devised the benefit design?

A. I'm not familiar with any.

Q. Let's see. Further on down, the last paragraph on this page, you say that PBMs also rely on their aggregated population groups for leverage when negotiating with drug manufacturers for rebates for their managed care organization or MCO clients.

These large population groups give the PBMs the ability to influence market share of pharmaceutical products through their formulary process and pharmacy benefit plan design features. And then you add in the last sentence of that paragraph that the rebates that pharmaceutical manufacturers pay to PBMs are often tied to the market share of their pharmaceutical products.

Are you familiar with the phrase "market-share incentive rebates"?

A. Yes, I've heard that phrase.

Q. What do you understand by a market-share incentive rebate?

A. Market-share incentive rebates, to my understanding, are provided in an incremental fashion if a particular drug market share that a client is contracted for achieves certain percentage plateaus of growth relative to the market share in general.

Q. And are market-share incentive rebate contracts common in the industry?

A. I would say they are, yes.

Q. If I could, I'd like to show you a document that I'll mark as Exhibit 849.

(Exhibit No. 849 marked for identification.)

Q. By the way, are you familiar with the Drug





Cost Management Report?

A. I think I may have seen that in my activities.

Q. But that's not something that you regularly subscribe to or see in the course of your duties?

A. Not regularly, no.

Q. And let me show you a copy of the Drug Cost Management Report dated June of 2002, and ask you, have you ever seen this document before, to your knowledge?

A. (Witness reading.) Who wrote the article? Susan -- she's with --

MS. COURVILLE: Sorry, are you looking at a particular article in this?

MR. EGGERT: The first article in here is "Uncovering the Mysteries Behind Rebates."

A. Susan works for AIS, I believe.

MS. COURVILLE: I think this is the article he's talking about.

A. Oh, Chris Nee? Yeah, seems to me I just read an article by Chris Nee. I know Chris very well and have worked with his company. So this may be the article you're referring to.

Q. (BY MR. EGGERT) What is Mr. Nee's company?

A. I was going to say Pharmaquest or Pharmedics





or -- I think he has it listed at the end of his article here. PharMedQuest, that's what it is.

Q. If you could look to the second page of his article, and the second paragraph under the bullet point "market-share or tiered rebates" states that drugs that compete in a crowded marketplace typically choose the MSR, meaning the market-share rebate, when negotiating with PBMs. Is that -- is that conclusion of Mr. Nee's consistent with your own experience?

A. As I mentioned, I think the market-share rebates have been common in the industry, so that would be consistent.

Q. In fact, can you name a single manufacturer of a significant pharmaceutical product that does not offer market-share incentive rebates?

A. Not as I sit here, I can't recall one way or the other.

Q. But you can't name one that you know doesn't offer them?

A. That's correct.

Q. And what would be the likely result to a manufacturer if it refused to offer market-share incentive rebates to managed care?

A. That would be speculation on my part; if that's what you want me to do, I would speculate that





they would have to negotiate some other type of rebate in order to receive favorable formulary position.

(Exhibit No. 850 marked for identification.)

Q. If I could, I'd like to direct your attention to a document which I'll mark as Exhibit 850. Are you familiar with a Chris Monovich?

A. He's a national account manager for Wyeth; is that correct?

Q. He may have been a national account manager for Chris Monovich -- for RxAmerica, I don't know.

A. I don't recall the name.

Q. If you look down at this memo under the phrase "Premarin family"?

A. Uh-huh.

Q. Indicating a meeting with Joe LaPine, by the way, the director of provider relations, and we spoke about him earlier, I think, and also Jerry Miller, director of clinical services. Do you know a Dr. Jerry Miller?

A. I do.

Q. What was Mr. Miller's role at RxAmerica?

A. When he was at RxAmerica, his role was director of clinical pharmacy services.

Q. And was he involved in the P & T committee in that capacity?

A. I think he was occasionally involved in the P & T committee, that's correct.
Q. What was the duties of the director of clinical services?
A. The director of clinical services was responsible for reviewing clinical pharmacy activity and patient profiling, disease management programs, drug utilization review programs with our clients.
Q. If you look under "Premarin family" here --
A. Uh-huh.
Q. -- it says the new competitors, Cenestin, FemHRT 1/5 and Prefest were all brought into the overall category discussion. This is Joe LaPine's way of reminding Wyeth-Ayerst not to take the Premarin Family category for granted, and that we must continue to provide rebates competitive with current offerings. Then he noted that generic estradiol can be purchased for much less than their Premarin net price, and adding that if Wyeth-Ayerst does not continue to provide rebates, Joe LaPine stated that we will lose our gains in this category.
Mr. LaPine was working for you at the time; is that correct?
A. November 10 of '99, that's probably correct.
Q. And he indicated to Wyeth that if they did





not continue to provide rebates, that Wyeth would lose its gains in the ERT category, right? Did he ever have any discussions with you about that?
A. I don't recall having such discussions with Joe about that.
Q. Did you recall having any discussions with Mr. LaPine at all about Premarin or Cenestin?
A. I don't recall that.
Q. Do you have any reason to disagree with the statement reported by Mr. LaPine that if Wyeth-Ayerst did not continue provide rebates, that it would lose its gains in that category at RxAmerica?
A. To the best of my understanding, Wyeth's contract required Premarin to be the sole conjugated estrogen on their formulary in exchange for rebates; and if those rebates went away, obviously other competing products could be added, which could have been a threat to Wyeth's market share of Premarin in that category. That's how I would interpret it.
Q. In your next paragraph here, you indicate that some larger PBMs rent their formularies to smaller PBMs?
A. Where are you on the report, please?
Q. This is on page 9, the first full paragraph on page 9, the --





A. Okay.
Q. -- second sentence there.
A. Got you.
Q. You indicate that some larger PBMs rent their formularies to smaller PBMs and then pass the rebates that are paid by manufacturers to the smaller PBM's clients' members. To the extent that that occurs, are those numbers reflected in the covered lives that you -- that you mention further down on the page for various PBMs?
A. I don't believe that in these covered lives they are counting formulary-only lives. It's possible, but I don't believe it is.
Q. What do you mean by "formulary-only lives"?
A. Well, in the case that I mentioned to you earlier where Integrated Health Concepts utilized the formulary that PCN provided, in that case, PCN would count the million covered lives of Integrated Health Concepts as part of their formulary lives. And further up the chain, Integrated Pharmaceutical Concepts, owned by Foundation Health Plan, would count the PCN formulary lives as their formulary lives. That's what I mean by "formulary lives," where they're -- the only function they are providing is formulary rebate services on those prescription





claims.
Q. And you don't know one way or another whether the covered lives listed in your chart include these formulary lives?
A. It's my belief that they do not. I negotiate directly with these PBMs in building networks for Integrated -- for Nex2, and part of that negotiation and part of Nex2's remuneration to the PBMs is based on what they call their covered lives. "Covered lives" refers to lives that are covered by a pharmacy benefit that the PBM offers.
Q. And not one that's simply rented?
A. It should not include formulary-only lives, correct. Because there's no covered benefit involved in administering programs for those patients.
Q. Do you have any estimates for the number of rented lives, I guess, that are -- that are out there for the various PBMs?
A. I do not.
Q. So you've not really factored that into your analysis or your opinion?
A. I have no knowledge of that. I've not used it for anything.
Q. Under the paragraph "PBM market consolidation," the last sentence -- the last two

sentences talk about how the total number of reported covered lives by PBMs, 400 million, significantly exceeds the total population of the U.S. primarily because of double counting. For example, a state government with 3 million members may contract with one PBM for retail services and another PBM to provide mail service. In this case, both PBMs would count the same 3 million members; and that's right?

A. Yes.

Q. Is that the primary source of the double counting, that you would have different PBMs covering the same people with different aspects of their coverage?

A. That's one major source. The other major source comes from the fact that many of the working households today have both spouses or both family members working, and they normally work for different companies, and it's quite often those companies will have health plans administered by different PBMs. Most often, the family's health plan and prescription benefit will cover not only that member but the member's dependents. They may have three or four children, so that total family might be six people. In that case, each of those PBMs is going to count all six of those people because they cover the primary as





well as the dependent of the primary family.

Q. And the family itself might have overlapping or duplicative coverage?

A. Yes. They would be found on the eligibility rolls of both PBMs.

Q. Now in circumstances where you have this kind of overlapping coverage or in the example that you cite in the text of the state government that has lives covered with respect to certain aspects of coverage by one PBM and other aspects of coverage by another PBM, it's true, isn't it, that if a particular drug is reimbursed by just one of those PBMs, the persons covered can get the drug, right, if they go through the right channel?

A. If a person is eligible on a PBM's benefit to receive a drug, whether it's their health plan or their spouse's health plan, they would be able to receive it either way.

Q. And in the government -- the state government example, if the PBM dealing with retail services, for example, didn't cover a particular drug, but the PBM with the mail service did, then the consumer could get the drug if they sent away for a mail order prescription, right?

A. As you've stated it, that would be correct.





Q. Now you've listed a number of the larger PBMs here with estimates of their covered lives. What's the source for the numbers that you -- that you have in this document?

A. The numbers in the document reflect the numbers that I've obtained directly from the PBMs in my negotiations with them for network participation with Nex2. And some of them reflect the most recent industry reports as well, but some of them are -- some of the industry reports lag behind where the PBMs actually are in their evolution of taking on more lives.

Q. So have you received documents or do you have notes of conversations with individuals from these PBMs setting forth these covered lives?

A. In the PBM network materials that I gathered and put together for Nex2, I have PBMs with covered lives listed.

Q. I don't believe those PBM -- those network materials have been provided to us as part of the materials that Mr. Bystrom relied upon, and we'd request those.

A. This particular chart came out of a Price Waterhouse report that was provided as part of the backup.





Q. So this chart came from a Price Waterhouse report?

A. The chart did, yes. A couple of the numbers, I trued up, based on my knowledge of what the enrollment actually is.

Q. But in reaching your opinions, you also relied upon the numbers that you've discussed with PBMs in the context of your work with -- what is the name of the organization?

A. Nex2.

Q. Nex2?

A. Yes, I relied upon those discussions.

Q. Let's see. If I could ask you to take a look once again at -- let's see, Exhibit 849, and if you go about -- I think it's on page 6. There's a listing of top PBMs by total covered lives. And the numbers are a little bit different than those provided in your report. I noticed that there were some PBMs that were listed here that actually weren't even listed in your report. Are you familiar with Argus Health Systems?

A. I am. They are located in Kansas City, Kansas.

Q. And they're listed here on this exhibit, at least, as having 24 million covered lives. Is there

some reason they were not listed in your report?
A. Yeah, Argus Health System is a little unique. They don't classify themselves as a PBM because they don't perform all the PBM services such as pharmacy network management, rebate negotiations, formulary development. They are more of a claims processor. Probably one of the best in the industry. They're moving towards developing a pharmacy network. They called me to ask if I would come to work for them and develop a pharmacy network because they want to be included as a full-service PBM. That's why they're not on this report.
And this report was not intended to be inclusive. It was intended to be exemplary.
Q. And further down, are you familiar with PharmaCare Management Services?
A. Yeah, they're located in Woonsocket, Rhode Island.
Q. Are they connected with a drug store in any way?
A. They're owned by CVS.
Q. CVS. They're ace listed as having 12 million covered lives. And they're a PBM, as far as you know?
A. They are.





Q. How about Anthem Prescription, further down, 4 and a half million lives. Are you familiar with them?
A. I am, yes.
Q. And then RxAmerica is listed here at 4.7 million lives; is that an approximately correct figure for the number of covered lives at RxAmerica?
A. Yeah, order of magnitude, it would be correct.
Q. By the way, are you aware that Argus now does have a formulary?
A. That would be new news to me. I knew they are moving in that direction, but I don't contract directly with them in my responsibilities for Nex2, so...
Q. Okay. On your report here, you listed I guess the tier 1 or the major PBMs as AdvancePCS, Merck-Medco, Express Scripts and Caremark. Why was it that you didn't also list WellPoint, which actually has more covered lives than Caremark?
A. The industry -- a couple of reasons. Number one, WellPoint has just achieved that number of lives within this year. Prior to 2002, their number of lives was under -- under 30 million, in the lower 20s, and the industry in general has considered these four





as the top PBMs. They usually -- they usually consider -- when you talk about the big PBMs, what they usually talk about is Advance, Merck-Medco and Express. They have been the industry leaders in PBMs for the last decade.
Q. Okay. So even though WellPoint has -- has more lives and has had more lives than Caremark, it hasn't been considered one of the top four; Caremark is considered --
A. Not until recently. Caremark has always been one of the top 4.
Q. Okay. And then on the next page, you say the four largest PBMs each manage greater than 20 million covered lives. In fact, it would be accurate, then, to say that the top five largest PBMs each manage more than 20 million lives, right?
A. You could probably add others in there as well.
Q. What are the others that you would add?
A. Depending upon how you're going to define a PBM, you may be able to add Argus Health Systems in there; MedImpact, you could add them in there.
Q. Okay. I think that the videographer needs to take a brief break to change a tape.
THE VIDEOGRAPHER: We're off the record





at 12:11.
(Short break 12:11 to 12:12 p.m.)
THE VIDEOGRAPHER: We're back on the record at 12:12.
Q. (BY MR. EGGERT) Sir, I'd also like to ask you about a couple of discrepancies between the numbers cited in your report and the numbers in the drug cost management report.
With respect to New Eckerd Health Services, you list covered lives at 5 million. And this report lists as the Eckerd Health Services covered lives at 16 million. Do you have any explanation as to why you might have those discrepancies?
A. The information that I get from Eckerd Health Care Services in terms of the contracts we're negotiating with Nex2 is they have about 5 million lives. They have other lives they count for other things, and some, they do mail service only with. But they don't count those in their -- in the covered lives that I deal with with them.
Q. But they might have more lives than -- that they deal with on a mail-order basis?
A. Mail-order-only basis. That's entirely possible. They run a large mail order business out of Pennsylvania.

Q. Pennsylvania. I grew up in Florida; I always think of Eckerd as being Florida based, but they're all over the country I guess, huh?

A. (Nodding.) They acquired Thrift; that's where their mail service was.

Q. Let's see. Another one -- let's see. Aetna is listed on your chart as being at 5 million. And then there's an entity known as Aetna USA Health Care Pharmacy Management which is listed at 11.1 million here. Do you have any explanation as to why we might have that disparity?

A. I do. Aetna, to my understanding, has a number of their clients that are actually processed through Express Scripts, about half of them, roughly. That's why I just list Aetna for those lives that are actually processed by Aetna.

Q. So there might be some double counting on this list here between the 50 million Express Scripts lives and the 11 million Aetna lives, for example?

A. That's possible, yes.

Q. Do you know with respect to the Aetna lives that Aetna processes through Express Scripts whether they use Aetna-derived formularies and benefit designs or whether they use Express Scripts benefit designs?

A. I don't know the answer to that.





Q. Okay. If you could look at page 11 of the report, and in the middle of that page in bold, you list three different kinds of drug formularies, an open formulary, an incentivized formulary and a closed formulary.

Could you explain to me what an open formulary is?

A. Yes. As I stated in my report, an open formulary is a listing of drugs that has no actual incentives tied to any particular drugs within a therapeutic category such that they can prescribe any drug that's available without any disincentives financially.

Q. Right. I was a little bit confused by the last sentence under "open formulary" in your report, which stated that some open formularies may contain patient incentives such as differential co-payments. Is that a mistake? Because in that sense, would that kind of open formulary be any different than an incentivized formulary?

A. It's really a matter -- it's almost like a gradient. There may be -- there may be some incentives within an open formulary and still considered open whereas an incentivized formulary has very definite incentives on the preferred drugs within





the formulary, and co-pay differentials, as well as incentives for the pharmacist and the physicians.

Q. Well, are you suggesting that if the co-pay differential is small, that it might still be an open formulary; but if the co-pay differential is great, then it's an incentivized formulary?

A. The manufacturer could consider it that way, depending upon how strongly the incentivized -- the incentive will drive utilization to the selected products.

Q. And I take it that if the spread or the differential between the co-pays differs among different benefit designs, that the -- the effect of being able to I guess encourage drug usage from one drug to another might vary; is that correct?

A. That's correct, yes.

Q. Let's see. And then what is an incentivized formulary?

A. Incentivized formulary has incentives involved for either the patient in terms of a higher co-payment or a third tier co-pay or the pharmacist in terms of on-line edits and messaging or the physician in terms of physician reporting and profiling, and possible even incentives by the payor for the physician to prescribe preferred products within that





formulary.

Q. And then a closed formulary, that's one where non-formulary products are not covered at all?

A. Correct.

Q. Now, you'd agree, would you not, that the -- that the effect of not being on a particular plan's formulary, that the impact of that is -- is different depending upon what sort of formulary we're talking about; is that right?

A. The positioning on the formulary could be different depending on which formulary we were talking about.

Q. Well, take a manufacturer whose product is not even on the formulary. So he's not on the formulary at all.

A. Uh-huh.

Q. Would the impact of that exclusion from the formulary be different depending upon whether the formulary in question was an open formulary, an incentivized formulary or a closed formulary?

A. It would be, correct.

Q. In that the manufacturer would be better off if it was an open formulary; is that correct, and worse off if it was a closed formulary?

A. Depending upon whether the drug were listed

or not, that's correct.

Q. Now, if we flip back to page 9, let's see. Do you have an understanding as to the percentage of the covered lives under, say, the AdvancePCS, the 85 million covered lives, what percentage of those are subject to open formularies as opposed to incentivized formularies as opposed to closed formularies?

A. I have a -- I have an opinion. I don't have definite -- any records to back it up.

Q. What's the basis of your opinion?

A. The basis of my opinion would be what I see happening in the industry in general.

Q. Well, let's -- let's talk about 1999, first of all, at the time that Cenestin was introduced into the marketplace. You're familiar that '99 was the year of the launch. In 1999, do you have a sense as to what the relative open, incentivized and closed lives were for the AdvancePCS formulary?

A. I don't have a real sense for that, no.

Q. And you've not considered that in reaching your opinions in this case?

A. I've not considered what type of formulary structure AdvancePCS had in 1999.

Q. Have you considered what sort of formulary structure any of the PBMs listed on page 9 had as of





1999 in reaching your opinions in this case?

A. I know that in 1999, the third-tier formulary design was just beginning to emerge, so the move to open formularies was more prevalent after 1999, towards 2000 and 2001. Formularies back in 1999 were more restrictive than they are today.

Q. And would that also be true, in your opinion, in 2000?

A. Well, as I say, they are more restrictive. It's my opinion that formularies were more restrictive in 2000 than they are today because of the development of a third-tier program, third-tier co-pay program and the tendency to want to make access more available to pharmaceutical products for plan members.

Q. Is the three-tier program, in your mind, the same as what you'd call an incentivized formulary?

A. It is -- the three-tier would be the incentive for the patient, correct.

Q. So when you refer to a three-tier formulary, you're referring to a type of incentivized formulary, correct?

A. Correct.

Q. And you believe that the emergence of three-tier formularies has led to less restrictions on what kind of drugs consumers can get; is that correct?





A. That's the intent of the three-tier formulary, and it depends a lot upon the differential between the payment of the second and third tier.

Q. And that varies from plan to plan?

A. It could vary from plan to plan.

Q. In reaching your opinions, did you consider at any time between 1999 and 2002 what the differential and the co-pays were with respect to any of the PBMs listed on page 9?

A. No.

Q. Might that be relevant to the impact of the conduct alleged in the complaint?

A. I'm not sure how that would be relevant to the -- to the alleged complaint. The complaint dealt with -- with sole-source contracting, which in effect would prevent a Cenestin product from getting on many of the formularies at all.

Q. Is it your understanding that if Cenestin was not on an open formulary, not listed on the formulary, that it would not be reimbursed by the formulary?

A. No, in an open formulary, as long as a therapeutic category is covered under the members' benefit, the drug products in that category would get reimbursed.





Q. And is it your understanding that if Cenestin were not on a formulary, that it would not be eligible for a third-tier co-payment?

A. No, that's not my understanding.

Q. So I guess I don't quite understand your point. Why is it that the fact that they were excluded from the formulary means that the co-pay differentials are not relevant? I would think that that is what makes them relevant.

A. The co-pay differentials would be relevant to Cenestin being prescribed and the member obtaining a prescription. If it's significant between the tier 2 and the tier 3 co-payment amount, it would have an impact on Cenestin being dispensed.

Q. In terms of the percentage of the various plans that were open and closed, why don't we take a quick look at -- let's see -- a document that's been marked as -- it's previously been marked as Exhibit 301. This was a document that's been produced in this case by Duramed. You're familiar with Duramed, are you not?

A. Uh-huh. Yes.

Q. And have you reviewed this document in the course of your work on this case? Is that one of the documents provided to you by counsel?

A. It's possible. I've looked at a number of documents.
Q. Did you consider this document in reaching the opinions in your report?
A. I may not have. I don't recall this specific document, but I may have read it.
Q. If I could direct your attention to the last page of the document entitled "PBMs formulary breakdown." And incidentally, this document is dated November 30th of 2000.
And it lists AdvancePCS and purports to list the percentage of lives covered by the open benefit, the three-tier benefit and the closed benefit for AdvancePCS. And do you see that, 75 percent open?
A. Uh-huh.
Q. Do you have any reason to dispute that estimate by Duramed that 75 percent of the lives covered by AdvancePCS were subject to open formularies?
A. No.
MS. COURVILLE: Objection. We don't really know how they're defining "open formularies" in this document, so the definition, as you know, might differ from what Mr. Bystrom has given us as his definition.





Q. (BY MR. EGGERT) Right. You said you read Mr. Finneran's deposition, right?
A. I read parts of it.
Q. Right. Did you read the portion of Mr. Finneran's deposition in which he explained what "open," "three-tier" and "closed" meant on this chart?
A. I may have. I don't recall exactly what his definitions were.
Q. Okay. Well, let's assume for a moment that "open" here means that they're covered at the same co-pay, and the "three-tier" means that they are not covered at the same co-pay, but that there is a higher co-pay for Cenestin than Premarin, and "closed" means that Cenestin is not covered at all.
Given that, let's take a look at Caremark. Once again, 75 percent of the lives are listed as open. Do you have any reason to dispute that figure?
A. I have no reason to dispute that.
Q. You didn't consider that 75 percent of the lives at AdvancePCS and at Caremark were open in reaching your opinions, did you?
A. I didn't consider this in reaching my opinions, correct.
Q. And did you consider the fact that in this





group of -- how many is it, one, two, three, four, five, six, seven, eight, nine, ten, eleven, twelve -- thirteen PBMs, accounting for 130 -- 140 -- 222 million lives, I'm sorry, that 62 percent of the lives covered were open, according to Duramed's calculations?
A. Was your question I didn't consider it; was that what your question was?
Q. Right, you didn't consider that in reaching your opinions?
A. Correct.
Q. Would this be at all relevant, in your view, to any of the opinions reached in your report?
A. My opinions would probably stay the same. I still believe that if a drug is not listed on formulary, the doctor is not going to be prescribing it, because they're used to prescribing drugs that are on formulary because it makes their life easier.
Q. Did you consider, in reaching your opinions, the fact that on those occasions when Cenestin got on formularies, that their market share with respect to those plans was no greater than it was with respect to those plans where they were not on formulary?
Were you aware of that?
A. I don't recall seeing that. I may have





reviewed that, but don't recall it.
Q. Did you consider that in reaching your opinions?
A. No.
Q. Might that be relevant to the opinions you reached in the case?
A. Over what time period did that cover? Do you know?
Q. I think it covered all periods of time in the complaint. But the facts will be the facts on it.
A. Yeah. It may or may not be relevant. I didn't consider it in my report.
Q. Let me see. Let's go back to your report, page 10.
Incidentally, by the way, you also didn't consider whether the percentage of particular managed care organizations were open or closed in the course of reaching the opinions in your report, did you, other than PBMs?
A. My report focused mainly on PBMs, but I am aware that managed care organizations have both open and closed lives.
Q. Are you aware of the relative percentages between open and closed in the managed care field?

A. Not specifically.
Q. So you didn't consider that in reaching the conclusions in your report?
A. Correct.
Q. Under C, the last paragraph, you indicate that PBMs offer formulary services to their clients as a cost containment tool. How is it that a formulary's services are a cost containment tool?
A. They offer formulary services. For example, RxAmerica provides their formulary which is driven by low WAP -- low AWP costs as tool to keep prescribers on a list of drugs that have low AWPs so their health plan costs are low.
Q. And your testimony is that RxAmerica looks only to AWPs in determining what the costs of the drug is for purposes of formulary inclusion, doesn't look to the total cost of the drug which includes the AWPs and the rebates that might be offered in connection with it?
A. The primary decision is made based on the AWP, and secondarily, the rebates would flow.
Q. So rebates are also considered?
A. Rebates are -- are part of the financials, but they're not the driving reason for drug selection on the formulary. Its formulary is designed as a





low-AWP formulary.
Q. And does RxAmerica differ from other PBMs in that respect?
A. To my knowledge, Medco, for example, has a prevalence of Merck products on their formulary; they're not always the least expensive AWP.
Q. Because Medco has been associated with Merck and owned by Merck, historically; is that correct?
A. That would be my assumption, yes.
Q. In the same way that RxAmerica had a preference for Longs Pharmacies as opposed to other pharmacies?
A. When they could.
Q. Let's see. If I could turn to 5 --
MR. EGGERT: Are you going to be breaking anytime soon?
MR. EGGERT: Yeah, I guess we want to break for lunch pretty soon, won't we?
MS. COURVILLE: I would.
MR. EGGERT: Just a couple minutes.
MS. COURVILLE: Okay.
Q. (BY MR. EGGERT) Let me show you a document which has been marked as Exhibit 800 --
MS. WIEGAND: 51, it should be.
Q. (BY MR. EGGERT) And 51. Entitled





"Principles of a Sound Formulary System." Are you familiar with this document?
A. This is produced by AMCP?
Q. I believe that to be the case.
A. Looks familiar.
Q. And --
A. Yes.
Q. And if I could direct your attention to the second page of the document under "drug formulary system," would you agree that it's a purpose of a drug formulary system for a PBM to --
A. I'm still not following where you are here.
Q. Oh, I'm sorry.
A. Page 2?
Q. Yeah, do I have the same document as you? Oh, it's actually the second page of the document, but page 1 of the article, I'm sorry. Under "drug formulary system." Would you agree that it's a purpose of a drug formulary system to, at the end of that sentence, "identify drug products and therapies that are the most medically appropriate and cost effective to best service the health interests of the given patient population"?
A. I would say in general, that's a correct statement.





Q. And that one component of that is to analyze drugs for their comparative therapeutic and clinical attributes, right?
A. That's correct.
Q. Now, have you ever examined the relative clinical or therapeutic attributes of Premarin and Cenestin?
A. I have not.
Q. And did you engage in any such analysis in reaching any of the conclusions in your report?
A. No. I wasn't asked to do that.
Q. As a pharmacist, do you consider yourself capable to engage in a clinical -- or a comparison of Cenestin and Premarin?
A. If I had the information available to me. I have not practiced clinical pharmacy behind the counter for a number of years, so I would need to review in order to do that.
Q. If you turn to the next page, page 2, the real page 2 this time, would you agree that clinical decisions on formulary inclusion should involve assessing peer-reviewed medical literature?
A. Yes, I would in general agree with that.
Q. That they should involve assessing randomized clinical trials?

A. That would be part of the clinical information review.
Q. Would you agree that drug comparison studies are the best sort of trials to have, ones that show head-to-head comparison to existing drugs?
A. I wouldn't disagree with that.
Q. How about pharmacoeconomic studies, what are those?
A. Pharmacoeconomics studies?
Q. Yes.
A. Studies that determine the actual cost of therapy, taking in all factors, in addition to drug costs, costs of -- per-member, per-year cost of pharmaceutical care, together with their health care costs and what the overall impact is.
Q. And would you agree that those should be taken into account in formulary decisions?
A. I wouldn't disagree with that.
Q. What is outcomes research data?
A. Outcomes research data has to do with longer-term studies to determine the actual outcome of the pharmaceutical therapy: did it, in fact, produce the results it wanted and did it have a positive or negative effect on the overall health care.
Q. And you'd agree that that should be





considered on the issue of formulary inclusion?
A. I wouldn't disagree with that one, either.
Q. You'd also agree, would you not, that -- further down on the page, that economic considerations should be secondary to decisions about the safety, efficacy and therapeutic need for particular drugs?
A. Yes.
Q. And if you turn to the next page, page 3, the discussion of the Pharmacy and Therapeutics committee, would you agree with the discussion here of the goals and objectives of a Pharmacy and Therapeutics committee that first they would objective appraise, evaluate and select drugs for the formulary?
A. Yeah, I would -- I would agree in principle with all of the recommendations put forth by the AMCP.
Q. Okay. Have you participated in the development of the AMCP standards?
A. I have not.
Q. But as a member of that organization, you accept those standards?
A. Correct.
Q. Let's see. If you could turn to page 4, do you see that also the AMCP indicates that the formulary system -- this is towards the bottom -- should enable individual patient needs to be met with





non-formulary drug products when demonstrated to be clinically justified by the physician or other prescriber?
A. That's correct. What they're referring to there, in my opinion, is an effective prior -- that prior authorization process, which would allow virtually any non-formulary drug to be included in a member's prescription drug coverage if the physician has petitioned an appeal and received approval by the either clinical review board or by the health plan to provide that coverage. But there needs to be a system in place to accommodate that.
Q. Right. Are you aware in this case that -- actually for those cases where Cenestin was not on formulary, that Duramed's marketing partner, Solvay Pharmaceuticals, urged Duramed to develop formulary packets that would encourage physicians to submit prior authorization requests for the drug?
A. I'm not aware of it. It doesn't surprise me.
Q. And would it surprise you if you found that Duramed decided that they wouldn't bother?
A. That the physicians wouldn't bother?
Q. That Duramed wouldn't bother to try to put together prior authorization packets for physicians.





A. Doesn't surprise me, because I don't think the physicians would be using them, either. It's a lot of extra work they have to do.
Q. So in your experience, physicians never submit prior authorizations?
A. No, in my experience, the prior authorization process can be quite cumbersome and time consuming for a physician, so they -- if possible, they would avoid that.
Q. The extent of cumbersomeness might vary from plan to plan depending upon what particular requirements a plan might put for a prior authorization, right?
A. Correct. And it may vary by drug as well.
Q. Let's see. The second -- the second bullet point under here indicates that the formulary system should institute an efficient process for the timely procurement of non-formulary drug products and impose minimal administrative burdens. Do you think that's also talking about the prior authorizations?
A. It may be. It would be an ideal situation.
Q. And that's the goal set forth by the -- by this organization --
A. AMCP.
Q. -- AMCP.

And to provide access to a formal appeal process if a request for a non-formulary drug is denied?

A. Correct.

Q. Does RxAmerica allow for that type of appeal?

A. Yes.

Q. To your knowledge, do most PBMs allow for that type of appeal?

A. As far as I know, that exists within the industry with most PBMs and health plans.

Q. And also, the final bullet point, that the formulary system should include policies that state that practitioners should not be penalized for prescribing non-formulary drug products that are medically necessary. Are you familiar with that?

A. I think that's an excellent policy.

Q. And that's the policy that's set forth by the AMCP?

A. Recommended by AMCP.

Q. Does RxAmerica abide by that policy?

A. RxAmerica does not deal directly with the physicians from a remuneration perspective --

(Sotto voce discussion with court reporter.)

A. RxAmerica does not deal directly with





remuneration for physicians. That would be between the physician and the health plan as far as non-formulary prescribing would go.

MR. EGGERT: If you want to take a brief break -- a break for lunch, maybe we could do that now.

MS. COURVILLE: Okay. Go off the record.

THE VIDEOGRAPHER: We're off the record at 12:41.

(Lunch break 12:41 to 1:34 p.m.)

THE VIDEOGRAPHER: We're back on the record at 1:34.

(Sotto voce discussion, defense table.)

MR. EGGERT: We're back on?

Q. (BY MR. EGGERT) Welcome back, sir. Are you familiar with the formulary status that Cenestin had on the plan at RxAmerica while you were there?

A. Not -- no, I'm not intimately familiar. I believe that -- well, I'm not, no.

Q. Did RxAmerica have a contract with Wyeth that precluded it from putting Cenestin on formulary, to your knowledge?

A. That's my understanding, yes.

Q. And would you have approved that contract?





A. I probably would, if Joe made that decision to do that.

Q. Do you think there was anything wrong with RxAmerica entering into that type of arrangement with Wyeth? Did they commit some violation of law, in your view?

A. No. That's perfectly legal to do that.

Q. Why? Is that commonly done in the industry?

A. I don't think it's commonly done, but with the predominant market share that Wyeth had with Premarin, it seemed to fit for that particular circumstance.

Q. And have you -- have you -- are you aware of other similar exclusive arrangements with respect to other manufacturers that had a large market share?

A. No, I'm not.

Q. But you haven't looked into that?

A. In my experience, I'm not familiar with that.

(Exhibit No. 852 marked for identification.)

Q. If I could, I'd like to show you a document which has been marked as Exhibit 852, and this is a document which was produced in the course of this litigation by Duramed. It's an electronic mail message from John Neeley, who's with Viking. Are you





familiar with Mr. Neeley?

A. No.

Q. To Mr. Marty Carter, who was the head of managed care at Duramed. I believe he's one of the individuals whose deposition you said you reviewed.

A. Saw the deposition, uh-huh.

Q. If you can turn to -- let's see. The one, two, three, four -- I think it's the sixth page of that exhibit, Duramed 010675 on the bottom, there's a discussion of RxAmerica, recording a discussion that someone from Viking had, I think Mr. Neeley had, with Mr. Joe -- was it LaPine --

A. LaPine.

Q. -- to go over the Cenestin presentation. He indicated that Joe indicated that the clinical team reviewed Cenestin and decided not to add the product to their formulary. "From the feedback I received, they felt there were not enough participants in the study. The bottom line is, they want to take a wait-and-see attitude and get some experience on the product before they add it to the formulary."

Would that be consistent with your experience that if a new product came into the market and didn't have a lot of participants in the study supporting it, that RxAmerica might take a

wait-and-see attitude?

A. It was not unusual to take a wait-and see attitude with new products entering the market till the clinical team had a chance to evaluate and present to the P & T committee.

Q. And you have no reason to disagree with the fact that -- with the statements suggested here that the reason that Cenestin was not added to the formulary was that the clinical review team reviewed it and decided not to add it because they felt there were not enough participants in the study?

A. Looks to me like that's one of the reasons. They also wanted to take a wait-and-see attitude to get some experience on the product.

Q. What -- why would -- why would a PBM want to take a wait-and-see attitude to look and see about experience on the product? What would they be waiting to see?

A. They may be waiting to see if the -- if there is an adoption rate by the plans or the physicians requesting it.

Q. In other words, to see if the product is able to generate demand -- physician demand and consumer demand in the marketplace?

A. That may be one piece. They also may want





to see and wait -- just wait and see how their current contract is behaving to the introduction of a new product as well.

Q. Might they also want to wait and see if there were adverse reactions in the marketplace to the drug?

A. That's certainly possible.

Q. And do you know whether Cenestin was ever able to generate sufficient physician demand in the marketplace that might have warranted its placement on the formulary?

A. Don't know that.

Q. What sort of demand would ordinarily be a prerequisite for formulary inclusion?

A. I'm not sure I could quote you on that, either.

Q. That wasn't your area of --

A. That was not my area of expertise.

Q. You would defer to Mr. LaPine on issues of that sort?

A. Mr. LaPine and Mr. Miller and the P & T committee. That was up to them to make those decisions.

Q. You did not use to interfere with or intervene in their decisions concerning what should be





placed on the formulary?

A. Correct.

Q. If you could look briefly at page 15 towards the bottom, under 4 -- the sentence -- the paragraph that starts, "In almost all cases, a PBM's P & T committee approval is necessary for changes to occur in their formulary." Then you add "P & T committees rarely drive these formulary change decisions, instead, they bless decisions made by the PBM's decision makers." I take it that wasn't true, you say, in the case of RxAmerica; they weren't simply blessing decisions that you made as to what should be placed on the formulary?

A. I didn't make those decisions personally myself.

Q. But you were the chief decision-maker of the PBM, were you not; you were the head of the organization?

A. Correct.

Q. Why did you state here that "P & T committees rarely drive formulary change decisions but merely bless decisions made by the PBM's decision-makers"? Is that a true statement, to your knowledge?

A. I think it is. The P & T committees accept recommendations from clinical pharmacists and also





from the -- Joe LaPine on making additions or changes in the formulary. And they would generally bless those decisions or approve them as long as they're not bad practice in terms of pharmaceutical therapy.

Q. Well, the P & T committee would first make the decision as to whether or not the product was clinically and therapeutically adequate, right?

A. Correct.

Q. And they weren't going to change their mind on that view simply because some decision maker at the PBM wanted to place the product on formulary, I take it?

A. Depending upon how much clinical evidence there was that the particular product may or may not be appropriate for use based on the studies they've seen. If it was neutral, in their mind, they would most likely bless the decision made by the PBM decision makers.

Q. But in a case where they felt that the product hadn't had enough participants in the study and hadn't clinically shown itself, then they wouldn't approve it; is that -- would that be accurate?

A. If they felt there were evidence indicating it was clinically inadequate or not a good clinical decision to have it on formulary, it would be

difficult for them to bless that decision to add it.

Q. Are you aware that in the initial study that Cenestin conducted to obtain FDA approval, that 77 percent of the participants had to be titrated upward to a 1.25-milligram dose as opposed to the standard .625-milligram dose in order to obtain relief?

A. Not totally familiar with that, no.

Q. Would something of that sort have been relevant, do you think, to a P & T committee in determining whether or not to give Cenestin formulary status?

A. Might be. The P & T committee uses clinical data to make their decisions; could be it would be, it might or might not be.

Q. Are you aware of the dosage levels of Cenestin that were approved by the FDA when Cenestin came into the marketplace?

A. To the best of my understanding, initially when it entered the marketplace, I think they came out with the one-dosage form.

Q. And is Premarin available in a much larger number of dosage forms?

A. Yes.

Q. Could the limited dosage forms available for a product impact its inclusion on formulary?





A. Possibly.

Q. Are you available -- are you aware of the indications for which Cenestin was approved by the FDA?

A. It's my under -- I'm not a clinical pharmacist, and just based on my review of the documents in this case, it appears to me that it was approved for use in menopausal symptoms.

Q. Vasomotor symptoms?

A. Yes.

Q. Was it approved for prevention of osteoporosis?

A. I don't know that it was.

Q. To your knowledge, is Premarin approved for the prevention of osteoporosis?

A. I believe it was. Uh-huh.

Q. And is Premarin approved for other indications as well that Cenestin is not approved for?

A. Seems to me in the review of the documents, there were conditions -- there were indications that Premarin had that Cenestin did not.

Q. But you're not aware of that, independent of your review of the documents produced in this case?

A. No, I'm not.

Q. Let me see. If I could, I'd like to show





you -- do you have 9? A document that we will mark as our next exhibit number, which will be 853. And this is a copy of the RxAmerica drug formulary in the year 2000.

(Exhibit No. 853 marked for identification.)

Q. Have you ever seen this document before?

A. I may have. I don't recall specifically. I've seen different forms of the RxAmerica drug formulary; whether I've seen the 2000 edition or the 2001 or which edition, I don't know.

Q. If you look at the first actual page of the document, not the cover page, but the next page, the one that's denominated WYE 160468, the second full paragraph there towards the middle, it states, "In addition to clinical considerations, the advisory panel evaluates the cost of treatment of therapeutically equivalent drugs and bioequivalency data provided by the FDA. With primary consideration to provide a safe, effective and comprehensive formulary, the advisory panel evaluated all therapeutic categories and has selected the most cost effective agents in each class."

At the time that RxAmerica made that statement in connection with its formulary, to the best of your knowledge, was that an accurate





statement?

A. To the best of my knowledge, it would have been accurate.

Q. And RxAmerica had made the decision to have Premarin on its formulary and not Cenestin with respect to the therapeutic category of estrogen replacement products, right?

A. That's my understanding.

Q. Let's see if you can turn a couple of pages over to the page which is denominated 160470. Under "function and scope," talking about the pharmacy and therapeutics advisory panel -- is that the same as the P & T committee, incidentally?

A. Yes.

Q. Under item number 2, it's one of their charges to maintain the RxAmerica drug formulary and to provide procedures for constant evaluation and modification of the formulary based upon an objective analysis of the safety, efficacy and cost effectiveness of each medication. That accurately set forth one of their charges, did it not?

A. Yes, it did.

Q. And do you have any reason to believe that they did not adequately fulfill that charge in connection with their decision regarding Cenestin and

Premarin?
A. The guidelines would apply to that decision as well as others.
Q. And you never -- you never suggested that they failed to comply by those guidelines in connection with their decision regarding Cenestin?
A. That's correct.
Q. Okay. If you can turn to page 160478, that's like the middle of the document, that's where they're actually talking about estrogens. I think it's page 18 in the small print on the bottom.
It lists various estrogens which I take it were covered by the -- by the formulary, right?
A. Correct.
Q. And estradiol was one such -- estradiol, with the Estrace being the brand name, was one such estrogen, right?
A. Correct.
Q. And I take it that nothing that Wyeth did prevented RxAmerica from putting estradiol or Estrace on the formulary?
A. Evidently not.
Q. And then estrogens conjugated, Premarin, has a one dollar sign by it. What does one dollar sign mean?





A. Dollar signs are a relative ranking of cost of therapy of the drugs that are listed such that a one dollar sign would be a more cost effective choice than perhaps a two dollar sign would be.
Q. So Premarin, in the view of RxAmerica, was more cost effective than Vivelle, Estraderm and Estring, which were other estrogens available on the formulary; is that right?
A. Evidently at that point in time, that's correct.
Q. Anything here that would suggest that Premarin was overpriced?
A. No.
Q. Okay. I don't have any further questions on that document.
If I could direct your attention to page 13 of your report. Under subcategory G, you indicate that PBM contracting with pharmaceutical manufacturers most often involves negotiations between the two parties to determine positioning of manufacturers' drug products on the PBM's formulary. I take it, then, that it's common for manufacturers and PBMs to have negotiations concerning where on the formulary the manufacturer's products will be listed?
A. That's part of the negotiation process, yes.





Q. Is there anything wrong with that?
A. No, that's pretty standard in the industry.
Q. In fact, if PBMs weren't able to do that -- that's what PBMs do, right; that's the whole idea of a PBM is to try to set up formularies and to make judgments as between drugs as to which are more effective and which are more cost effective, right?
A. That's correct.
Q. And the goal of that ultimately is to deliver lower-cost health care to the consumer; is that correct?
A. Pharmaceutically effective and lower health care costs. That's the goal.
Q. Down towards the bottom of the page, it indicates that in creating a drug formulary, the issue of rebates becomes paramount to the PBM when determining formulary positioning between drugs in the same therapeutic class. Is that generally true across PBMs, to your knowledge?
A. To my knowledge, that is, yes.
Q. And in particular, PBMs are more likely to give favorable formulary position to drugs that have -- that give them greater amount of rebates?
A. If everything else is pretty much equal between the two drugs, that would favor the one with





the higher rebate.
Q. And that's standard across the industry, isn't it?
A. To my knowledge, it is.
Q. Do you -- in this case, do you have an opinion that there was something wrong with Wyeth's use of market-share incentive rebates separate and apart from any provision in its rebate agreements that precluded -- that required that Premarin be the sole and exclusive conjugated estrogen on the formulary?
A. Probably not. Their behavior as far as negotiating market-share agreements and getting products listed on formularies, the parts we've discussed probably fall within the normal activity of the industry.
Q. But what you're more concerned with is that provision in some of the contracts with PBMs that required that Premarin would be the sole and exclusive conjugated estrogen listed on the formulary; is that right?
A. That's -- that's kind of unusual, correct, in my estimation.
THE VIDEOGRAPHER: Mr. Bystrom, could you move your microphone up a little bit? It's knocking against the table. Thank you.

Q. (BY MR. EGGERT) So you're not familiar with other exclusivity arrangements that other manufacturers have negotiated with PBMs?
A. Not -- not very familiar with a lot of those type of contracts in the industry.
Q. How about in the area of insulin, insulin medications?
A. I think Lilly had some exclusive arrangements for quite some time until competitive products came out.
Q. And isn't it common for manufacturers to give PBMs greater rebates if they have either an exclusive status on the formulary with respect to a therapeutic category or if they are one of only a small number of drugs?
A. That would be correct.
Q. And in fact, a number of PBMs actually send out bid grids that require manufacturers, in bidding, to fill out different percentage rebates premised on the level of exclusivity that would be provided on the particular formulary; is that right?
A. That might be one of the factors on the bid process.
Q. RxAmerica doesn't engage in that time of bidding process, to your knowledge, or --





A. Not to my knowledge, no.
Q. But are you aware of some of the PBMs that do?
A. After reviewing the documents that were given to me, it appears that some of the PBMs do that.
Q. You weren't aware of that before you reviewed some of the documents that were produced in this case?
A. I was aware that PBMs submit requests for proposals for formularies, but I was not aware of what you call the bid grid process and the type of process that was used by some of the other PBMs.
Q. Express Scripts would be an example, wouldn't it?
A. Yes, uh-huh.
Q. If you look on page 14 of your report, let's see. The third paragraph. The one that starts, "As the PBM industry competes aggressively for new clients, the PBM profits derived from their administration fees has diminished and their manufacturer rebates with their associated administration fees have become a more significant component of the PBM's totality profitability."
First of all, is there any difference





between administration fees and administration fees that are associated with manufacturer rebates? I found this sentence a bit confusing.
A. They're for different purposes, yes. Administration fees that I refer to in the beginning of that statement refer to claims processing fees, fees for maintaining eligibility, fees for providing services to the payor.
Q. And is that generally the 2 or 3 percent administrative fee that a PBM would negotiate with an MCO?
A. Yeah, generally it will be 30, 40, 50 cents, a dollar in the old days. That was what's called the admin fee that they would negotiate with the payor for payment of their services.
Q. Okay. And then there's a different kind of administration fee?
A. Well, the administration fee or service fees that are associated with rebates have to do with the activities involved in administering the rebates and the submission for payments back to the -- to the drug manufacturer.
Q. But is there a separate administration fee charged for that in the contracts or are you just referring to --





A. No, no, no overall -- overall profitability of the PBM is derived from administration fees from their client as well as administration fees they receive from the drug manufacturer in managing their rebates. There's several fees involved in profitability.
Q. I see. So here, you're talking about the administration fee which is received from the manufacturer. Those are the ones that are associated with the rebates?
A. Those are the ones associated with the rebates, correct.
Q. And those are the -- that's the 2 or 3 percent that a manufacturer might pay to a PBM in addition to whatever the percentage rebate is?
A. That's correct.
Q. And the administration fee is something that the PBM will not generally or ever pass down to its clients, whereas the rebate itself might get passed down, in whole or in part, to the client plans, correct?
A. Correct.
Q. When you state that for some PBM brand drug manufacturers, rebates and associated fees account for over 50 percent of their total gross margin dollars,

can you break that down for me as to what portion of that is the rebates and what part is the associated fees?

A. Probably really can't, because from my experience, they're lumped into rebates in general as a line on the P & L.

Q. What's the basis --

A. So the -- if the rebates are in the area of 5 to 10 percent and the admin fees are 2 to 3 percent, they may be close to the same, because a portion of the rebate actually goes back to the -- to the client. But that would be speculation on my part as to the exact amount and breakdown.

Q. I mean, it's true, isn't it, that in -- in recent years, a greater and greater number of the plans are demanding that a larger and larger percentage of the rebates be passed down to them; isn't that true?

A. It's correct that the clients are becoming more aware of the rebates and what they should be asking for.

Q. Right. In the early days of the PBM industry, clients might have been ignorant and they didn't know that the PBMs were pocketing large amounts of rebates, but clients now are aware of that fact and





they demand their share of the rebates, right?

A. I think as the cost of health care goes up, everybody is looking for where they can find more profit opportunities.

Q. The next paragraph, you talk about Medicaid best-price rebates. Could you explain to me how that works?

A. Yes. The Medicaid -- governmental prescription drug program for Medicaid recipients requires drug manufacturers to pay rebates to be listed on their formulary as well, and they have a -- they have a threshold that's listed as 15.1 percent, and they call that the best-practices threshold; and if a manufacturer gives a rebate to a private entity that exceeds the best-practice threshold that the government has established, then they would also be required to give that same amount to the government so that the government is not disadvantaged in the formulary rebates.

Q. Why do you include that in your report; why is that relevant to your analysis?

A. Just educating the reader of the report that rebates usually fall within a certain range --

Q. So --

A. -- and they have a ceiling that is





artificially imposed by the best-practices rebate to Medicaid.

Q. So your suggestion is that the rules related to Medicaid best prices act as a sort of ceiling and discourage manufacturers from rebating more than 15 percent?

A. Correct.

Q. Kind of -- yeah, a most favored nations clause, kind of, for the government?

A. Correct.

Q. You're aware, are you not, that both Wyeth and Duramed offer rebates to entities above the 15 percent level?

A. That could be possible.

Q. And if that's true, does this analysis really pertain to Cenestin and Premarin? Is it particularly pertinent to the analysis of those two drugs?

A. It's pertinent to the PBM industry and the way manufacturer rebates are negotiated.

Q. So would you be surprised if Wyeth offers rebates to some PBMs or MCOs in excess of 15 percent?

A. Probably not.

Q. And would you be surprised if Cenestin offered rebates to MCOs and PBMs in excess of 15





percent?

A. I would not be.

Q. In fact, if I could show you a document marked as Exhibit 854 --

(Exhibit No. 854 marked for identification.)

Q. -- and direct your attention to the second page. This is a document produced by Wyeth in this litigation under "government strategy, Medicaid," towards the bottom there, listing the discounts offered to Medicaid, it ranges from 63 to 66 percent. That's a fairly substantial rebate, isn't it?

A. Yes, it is.

Q. And that shows that Wyeth is competing vigorously in offering significant rebates with respect to the Medicaid business, does it not?

A. It demonstrates that they're offering significant rebates to the Medicaid system.

Q. And that's just an expression of low prices and good price competition, isn't it?

A. You could interpret it that way.

Q. Do you have any other way to interpret it, based on your opinions in this case?

A. The only other way I could interpret it would be if they were -- and I don't -- I'm not sure they can do it with Medicaid, but if they were trying

to buy exclusive positioning or excluding others from being able to compete in that same area.

Q. But you're not aware that Medicaid offers exclusive positioning, are you?

A. I'm not aware of that, no.

Q. And certainly, that's not one of the opinions that you've expressed in your report?

A. I have not.

Q. I'd like to direct your attention to page 19 of your report. Starting with page -- yeah, page 19. On pages 18 and 19, you're talking about NDC blocks. Would NDC blocks be an item that is used in connection with what you called incentivized -- incentivized formularies or closed formularies?

A. NDC blocks would appear in closed formularies.

Q. In closed formularies. Would they appear in any other type of formulary?

A. They would appear -- in formularies? Offhand, I can't think of instances where they would.

Q. Okay. Other than closed. Have you done any analysis to determine how often, if at all, NDC blocks were used against Cenestin?

A. I have not.

Q. So you don't really have a view as to





whether NDC blocks were ever used against Cenestin in the marketplace?

A. I've not done any analysis in that area.

Q. And your opinion in this case is not based in any way on the use of NDC blocks against Cenestin?

A. It's based on the negotiations to have NDC blocks put in place against Cenestin.

Q. But do you know if any of those negotiations were successful?

A. I don't know.

Q. If they weren't successful -- if they were not successful, what impact would they have had on Cenestin?

A. If they were not successful, the NDC block wouldn't have occurred on Cenestin.

Q. And there would have been no impact on Cenestin, right?

A. From an NDC block, correct.

Q. And you don't know one way or the other as to whether they ever occurred, right?

A. That's correct.

Q. How about soft edits? Do you know -- do you know what sort of soft edits, if any, were used with respect to Cenestin?

A. The -- PCS had a program called the





Preferred Drug Program, in which the pharmacist was incentivized to change a drug from a non-preferred to a preferred drug if a non-preferred drug was adjudicated across in their program. So there were edit messages put in place to instruct the pharmacist to call the doctor and make a decision to change the drug from a non -- that wasn't preferred -- it was performance -- they called it performance drug plan.

Q. Right. And in fact, the number of drug products listed on the performance drug list was much smaller than the number of products listed on the PCS formulary, right?

A. It was a subset within the formulary.

Q. Right. So that even if a product was on the formulary, if it wasn't on the PDL list, it could still be subject to those soft edits, right?

A. Soft edit does not stop a prescription from being adjudicated and filled, that's correct. It's a advisory message.

Q. It's an advisory message and thus doesn't stop the prescription from being filled; in addition, even if Cenestin had been on the formulary, if it weren't on the PDL, it could have still been subject to those soft edits, right?

A. That's correct.





Q. Do you have any reason to know that in 1999, Cenestin would have been placed on the PDL at PCS absent any of Wyeth's alleged contact?

A. I have no knowledge of that.

Q. How about prior authorizations? -- Oh, incidentally, do you know of any measures of the efficacy of soft edits in actually switching -- switching drug utilization from one drug to another?

A. I've not seen any outcome studies from that.

Q. On prior authorizations, have you done any analysis to determine the extent to which prior authorizations were required with respect to Cenestin?

A. I've not done any analysis of that, no.

Q. Does -- does your opinion rest in any way on the extent to which prior authorizations were required for Cenestin?

A. No, my opinion rests on the negotiations which involved negotiating for prior authorizations to be placed on Cenestin, not on the result of the negotiation.

Q. So your opinion rests on merely, what, Wyeth discussing with PBMs the possibility that prior authorizations might be put into place against Premarin even if they never were put into place?

A. That's correct. It's based on the behavior of Wyeth asking for and requesting those prior authorizations and/or hard edits be placed on Cenestin.

Q. To the extent that Wyeth was unsuccessful in obtaining any prior authorizations, what impact would that have had on Cenestin in the marketplace?

A. If they were unsuccessful, they would have no impact because they wouldn't have been put in place.

Q. And which particular entities did Wyeth have discussions with concerning prior authorizations?

A. To the best of my memory, and there's a couple cases cited in here, they had discussions with Health Net and IPS and Aetna, I believe, for placing hard edits as well as NDC blocks -- NDC blocks as well as prior authorizations. There may have been others, but those are the ones I recall as I sit here.

Q. Is an NDC block the same as a hard edit to you?

A. That would be the same as a hard edit, yes. Stops the prescription-filling process.

Q. Anyone else that you remember?

A. Not as I recall sitting here this afternoon.





Q. And you don't know what ultimately came of any of those discussions?

A. That's correct.

Q. Did you inquire --

A. Although I believe -- I believe in the information I saw on Health Net, Alan Jacobs indicated that the NDC blocks were in place.

Q. With Health Net?

A. Yeah.

Q. And who's Alan Jacobs?

A. He was the director of pharmacy for Health Net at that time.

Q. If I could refer you to page 20, it indicates under section D -- by the way, before I even do that, the last sentence here, the top sentence on the page says, "a step therapy protocol may require a physician to prescribe older and less expensive drugs in a therapeutic class before prescribing newer and more expensive equivalents."

What did you mean by including that in your report?

A. I included that under "prior authorization" to indicate that the prior authorizations may be quite cumbersome for a physician if it requires him to go through a step therapy protocol process where he has





to have -- demonstrate failed therapy with drug A before he can prescribe the non-formulary drug B.

Q. Was that relevant to Cenestin and Premarin?

A. It's relevant to prior authorizations.

Q. Do you know if any entity ever entered into a prior authorization requirement that would have required physicians to show that the patient had -- was not successfully treated with Premarin before Cenestin could be made available?

A. I don't know that.

Q. Did you ever see any negotiations even concerning that matter?

A. I saw negotiations where prior authorizations were discussed and requested. Whether they were successful or not, I can't tell you.

Q. And to your knowledge, those discussions didn't involve step therapy, did they?

A. I'm unaware whether they involved step therapy or not.

Q. Let's see. Under subsection D, you indicate pharmacy retailers have minimal control over which drug product is dispensed and minimal impact on influencing the market share of a given drug product because up to 90 percent of drug product selection is directed by formularies or preferred drug lists of PBM





clients.

Is that in accord with your understanding of the pharmaceutical industry?

A. In general, that is, yes. The pharmacy retailers are generally subject to their contracts, which require formulary compliance of their dispensing.

Q. So there's not a whole lot that a pharmacy can do to affect the demand of a drug?

A. They can do therapeutic interventions with a physician, for example, like the PCS, PDL program where they can call and recommend another drug be replaced -- be switched for the drug that was dispensed. They can do that.

Q. And that's a program they're doing in conjunction with a PBM, right?

A. Correct.

Q. How about just on their own, without --

A. Some pharmacy retailers in instances where substitutable products are available without contacting the physician, will favor one product over another.

Q. Referring to generic substitutable products?

A. No, even multi-source brands where you have two products that are -- can be readily

substitutable. They may have flags in their system to indicate to the pharmacist to use preferred drug A over B in that situation. So they can influence market share to some extent.

Q. Is that permitted in California; can a pharmacy substitute one branded product for another?

A. If it -- if they're AB rated and they're the same therapeutically and bioequivalent products, they can do that.

Q. So they have to be generic substitutes and be AB rated in order to --

A. They have to be substitutable. They're not generics, but they're substitutable products.

Q. To your knowledge, is Cenestin AB rated with Premarin?

A. Not to my knowledge.

Q. So it's not substitutable in that way?

A. Not without contacting the physician.

Q. Right, so a pharmacist can't do that sort of substitution between Cenestin and Premarin?

A. Correct.

Q. Let's see. Do you have any reason to believe that pharmacies actually did -- did anything that appreciably affected the market share of Cenestin vis-a-vis Premarin?





A. Not that I'm aware of.

Q. How about Long Drug Store, did they do anything to affect the market share of Premarin versus Cenestin?

A. I'm unaware of anything that they have done in that area.

Q. Are you aware of whether or not Longs Drug Store has a shared success agreement with -- or has ever had a shared success agreement with Wyeth?

A. I'm not aware of that.

Q. How would you -- how would you summarize the opinions that you plan to issue in this case? What are your opinions that you reached?

A. A couple of things: Number one, explanation of the retail pharmacy market and the PBM market, those are information that I can introduce at trial; and opinions that Wyeth introduced a preemptive plan to -- that was with an objective focused at keeping their competitor from gaining market share; that they entered into sole-source contracts with major PBMs and HMOs with the intent of keeping Cenestin off the market, and leveraged their financial rebates to keep those contracts in place; and that Wyeth negotiated with PBMs, requesting that specific NDC blocks and hard edits or prior authorizations be placed against





their competitive product; and in one instance, they even negotiated with at that time the largest PBM in the market, Medco, not only did they negotiate market share on their own product, they negotiated rebates based on Medco reducing the market share of their competitors' products.

Q. Let me ask you about that: What's the difference between negotiating rebates based on an increase in the manufacturer's market share as opposed to negotiating rebates based on a decline in the competitors' market share? Doesn't it amount to the same thing?

A. You may have the -- you may end up at the same point, but I think it gets to be predatory when your activities and tactics are focused on negative impact to your competition, specifically trying to disadvantage them in the market as opposed to working in a positive fashion with your own product.

Q. Now, would it affect your view at all on that contractual provision if you were to learn that, in fact, that provision emanated from Medco and not from Wyeth?

A. It really wouldn't. I think the behavior still exists.

Q. But it would, it would impact -- you seem to





have a focus on your opinions on what Wyeth's intent is. You want to opine about why -- its intent; is that correct?

A. I want to -- my opinion is based on what Wyeth's strategy and plans were relative to their formulary positioning with the PBM market.

Q. And how do you know what Wyeth's strategy and plans were?

A. From their preemptive Premarin plan and from the documents that I've reviewed in the case having to do with their negotiations with the PBMs.

Q. Other than reviewing the documents in the case, do you have any other basis for opining as to what Wyeth's intent was with respect to its preemptive plan, that you call it?

A. It's based on what I've reviewed in the documents in the case.

MS. COURVILLE: Objection, it's not what he calls it; it's the name of the document, "The Preemptive Plan."

Q. (BY MR. EGGERT) Are there any other opinions that you expect to render other than those?

A. Any other opinions would be basically supporting those positions that Wyeth entered into contracts to keep Cenestin off formulary with PBM --

major PBMs and HMOs, and that they used their rebates to leverage that activity. And I also feel that in instances I reviewed, that Wyeth was bundling their rebates in such a way -- and that bundling rebates is not uncommon in the industry -- but they were offering rebates on multiple products and multiple product families; and whenever -- on the documents I reviewed, it appeared that whenever a PBM wanted to consider placing Cenestin on their formulary, Wyeth made it evident that all of their rebates could go away if they were to place a product in that one category.

Q. Did Wyeth ever do that to anyone?

A. Didn't appear that they needed to.

Q. If Wyeth had done that; I mean, let's suppose that someone had called the bluff, so to speak, wouldn't Wyeth be shooting itself in its own foot by removing its rebates with respect to other products? What would happen to Wyeth's sales of those other products?

A. I don't know. It didn't happen, so I can't speculate on that.

Q. Take the example of oral contraceptives. Does Wyeth have a dominant share in the marketplace for oral contraceptives?

A. Not to my knowledge.





Q. So if Wyeth were to no longer provide rebates to oral contraceptives in managed care plans, would it not be predictable that Wyeth's share of the oral contraceptive market would plunge?

A. Could be.

Q. And that would hurt Wyeth's sales, wouldn't it?

A. In that category, it would.

Q. And you say that bundling rebates is not uncommon in the industry?

A. It's not uncommon for one manufacturer to offer rebates on multiple products and offer them as a bundle to a PBM.

Q. What are some other manufacturers that engage in that kind of bundling activity?

A. Without naming specific products, I believe Schering has done that, and I believe Parke-Davis has done that. And I suspect that others have done that as well.

Q. And are you aware that Wyeth actually bundles rebates far much less frequently now than it did say three or four years ago?

A. I'm not aware of that.

Q. Do you have any opinions with respect to the shared-success program that you intend to render in





this case?

A. The only opinion that I would render in the shared-success program was based on the documents I reviewed. It was Wyeth's intent to go out and renegotiate those to secure their position with retail pharmacies to make -- to prevent Cenestin from entering into any kind of relationships with retail pharmacies in a similar fashion.

Q. And do you have any idea as to how many shared-success agreements, if any, they actually renegotiated?

A. I do not, no.

MR. EGGERT: Can we take a break for just a couple minutes?

MS. COURVILLE: Absolutely.

THE VIDEOGRAPHER: We're off the record at 2:23.

(Short break 2:23 to 2:34 p.m.)

THE VIDEOGRAPHER: We're back on the record at 2:34.

Q. (BY MR. EGGERT) Sir, if I could direct you to page 11 of your report, about three quarters of the way down underneath the bold and italicized paragraph there, you say that evidence of the prevalence of different formulary types is mixed, and then you





indicate that about three fourths of HMOs have preferred or closed formularies, 45 percent preferred or partially closed and 27 percent closed; and then you cite an article in Novartis 1999 or a study from Novartis of 1999?

A. Uh-huh, uh-huh.

Q. Should you have said "had as of 1999"; are those figures accurate as of the present time?

A. This was as of 1999.

Q. Okay. And then even as of 1999, if I could direct your attention to what's previously been marked as Exhibit 301 -- let's see where that was.

Okay. If you can look -- we already looked at the last page of that document which dealt with PBMs. If you turn two more pages towards the front from the back, there's an HMO formulary breakdown that was computed by Duramed -- by the way, stepping back for a moment, in your experience, isn't it possible that even if a particular MCO has plans that are classified in general as open or incentive-based or closed, that with respect to particular drug products, it can make exceptions and allow that drug product to be made available at the same co-pay to its members even if it would not normally qualify under its plans?

A. They have the mechanics to do that, correct.

Q. In the course of reaching your opinions in this case, did you examine the extent to which that actually occurred in the marketplace with respect to Cenestin?

A. I did not.

Q. Well, let me represent that the formulary breakdown here is meant to incorporate that the way Premarin -- the way that Cenestin was actually treated on plans of HMOs and PBMs; and if you look at this page under HMOs' formulary breakdown, it expresses the view that in cumulative, that a number of HMOs -- and they go on for pages and pages before, there's probably over a hundred of them -- cumulatively accounting for 113 million lives, that of those, 65 percent of those lives were open, meaning that they were at the same co-pay level; 11 percent were at the 3-tier level; and 24 percent were closed.

Those numbers are actually somewhat lower with respect to the incentivized and closed than the numbers as revealed in the Novartis article, are they not?

A. They appear to be, correct.

Q. If, in fact, you had been looking at these numbers as opposed to the Novartis numbers, might that have impacted in some way your opinions as expressed





in your report?

A. Probably not.

Q. Why is that?

A. My opinions are based on what I saw as their behavior and their plan and their objective to disadvantage their competitor in the marketplace.

Q. So your opinions are really based more upon what you saw as Wyeth's objective and not in terms Wyeth's actual effect on the marketplace; is that fair?

A. That's fair. It's not based on the outcome.

Q. What is it, in your opinion, if anything, that would qualify you as opposed to other people to express an opinion as to what Wyeth's intent was, other than the fact that you've reviewed some of the underlying documents in the case?

A. What would qualify me to comment on their intent? Was that your question?

Q. To opine on what their intent was, yes.

A. Well, I think my years in the industry, in the pharmacy and PBM industry; and then being able to read their preemptive plan, which had their main objectives stating to reduce or keep their -- their competitors' market share at an absolute minimum,





that's where I would derive that ability to come forth with that opinion.

Q. Right. Well, for example, could Miss Courville read the preemptive plan as well as you and come to a conclusion about what their intent might have been?

A. I think anybody reading that document could understand what their objective was.

Q. So what -- is there something that qualifies you to be more able to discern their objective than anyone else?

A. I think my years in the industry qualify me to understand how the industry works and get a feel for how that objective might differ from other companies in formulating their business strategies and business plans.

Q. Anything else?

A. That's all that comes to mind. Let me just add one other thing. I have had a lot of experience in dealing with pharmaceutical manufacturers and on their advisory committees and listening to their plans, so I think that also helps to qualify me to come up with an opinion on what I saw here.

Q. And in the course of your advisory -- have you found a lot of manufacturers that you think were





engaged in exclusive type of plans and preemptive plans?

A. I don't recall any of the manufacturers that I dealt with that were developing plans with the objective of disadvantaging their competition.

Q. So in the course of dealing with pharmaceutical manufacturers, you didn't develop any special expertise, then, in the area of manufacturers that are trying to disadvantage their competition?

A. I didn't develop any expertise in that area, no. The...

Q. Now, I take it you -- you don't have an opinion to express as to whether, in the absence of Wyeth's alleged conduct here, that Cenestin would have obtained access to PBM formularies?

A. That's correct.

Q. And you'd agree, would you not, that there are a number of different reasons other than Wyeth's contracts that might have accounted for Cenestin's inability to get on certain formularies?

A. There could be other reasons.

Q. Have you -- have you considered the fact that Cenestin actually is on a number of formularies in reaching your opinion?

A. I'm aware that it is on some formularies.

Q. What formularies are you aware of that it's on?
A. It's now on the AdvancePCS formulary, although it wasn't during the time this was going on.
Q. And that's about 85 million lives?
A. It is today. Yes. Uh-huh.
Q. Right. It was fewer in the earlier periods, right?
A. (Nodding.) I can't specifically cite others, but I know in reading documents such as this, they indicated that they did have formulary position with some smaller plans.
Q. Do you consider WellPoint to be a small plan?
A. At that time, WellPoint was probably between 15 to 20 million members; they would be a relatively significant player.
Q. And now they're up around 30 million, right?
A. I think they're over 30 million, yeah.
Q. And Argus, you consider that to be a significantly sized plan?
A. They are today. I'm not sure where they were in 1999 and 2000.
Q. Let me show you a document which I'll mark as 855? 855.





(Exhibit No. 855 marked for identification.)
Q. This is a copy of a letter that Miss Courville kindly sent to a number of us. It attaches some interrogatory responses, they're called, in this case.
Have you ever seen this document?
A. I'm not sure if I've reviewed this document or not. It's certainly possible, but I don't specifically recall it as I sit here.
Q. It lists a number of formularies that Cenestin is on, including a number of Blue Cross plans up here at the top, a number of Humana plans. Is Humana a significant player in the market?
A. Fairly much so.
Q. Eckerd Drug Company, which we've seen -- they list here as 4 and a half million lives; we've seen it listed somewhere as high as 16 million, right?
A. Correct.
Q. PharmaCare, CVS, is on here listed as 4 million; I think we've seen that as high as 12 million on another document, right?
A. Yes, uh-huh.
Q. Have you heard of Keystone Mercy Health Plan? It's a Blue Cross plan.
A. I'm not familiar with Keystone.





Q. Prime Therapeutics; are you familiar with that plan?
A. They're a PBM. I am familiar with them.
Q. Are they located in California?
A. They are located in Minneapolis.
Q. Minneapolis.
MS. COURVILLE: By the way, Dave, I've just found out that Prime Therapeutics should be removed from that list, and we will be serving corrected interrogatory answers.
MR. EGGERT: Yet again.
MS. COURVILLE: Sorry. As I get it.
Q. (BY MR. EGGERT) Let's see. Express Scripts is listed here with respect to the expanded formulary bid grid. Are you aware that they -- that Cenestin was on the expanded formulary for Express Scripts?
A. I was unaware of that.
Q. Anthem, are you familiar with that plan?
A. They're a PBM, I'm familiar with them.
Q. Are they, you know, a fairly significant comparable, say, to RxAmerica?
A. In that same tier.
Q. But I take it it wasn't relevant to you in the course of your analysis that, in fact, Cenestin had obtained access to a number of -- number of





formularies?
A. I based my opinion on the documents in the preemptive plan that I read, and also the documents that involved interactions between Wyeth and various PBMs in the industry.
MS. COURVILLE: And objection, that list is as of today, July 2002. Many of the plans that you've mentioned, only recently did Cenestin get on the formulary. So I'm not really sure what the relevance of your question is.
MR. EGGERT: I take it you're seeking injunctive relief in the case.
MS. COURVILLE: Well, but you've asked him about a plan that was 1999 and you're asking him about formulary positions that we achieved yesterday, so...
Q. (BY MR. EGGERT) You indicate in your report that -- I think you say at one point that formulary status is the holy grail, and that it's the most important factor in marketing a product; is that your opinion?
A. That's my opinion, based on what I've seen in the industry and conversations with drug manufacturers and the fact that if you can't get position on a formulary, you don't have much chance of

achieving market penetration.

Q. Are you aware of products like Celebrex and Vioxx that have actually done quite well in the market without achieving appreciable formulary penetration?

A. There may be products that have done quite well without achieving formulary penetration that are unique in the industry in terms of their drug classes that don't have relatively good formulary alternatives.

Q. And are Celebrex and Vioxx among those?

A. They're the brand-new category of Cox inhibitors that are unique to the industry. I think they call them Cox-2 inhibitors.

Q. Uh-huh. And do you think that formulary status is more important than the clinical efficacy of a drug in order for it to achieve success in the marketplace?

A. Well, I think they have to have both. I think they have to be clinically effective in order to gain formulary status. And they need to be on formulary in order to be widely prescribed.

Q. And how about the way that the product is detailed to physicians; is that important to its success?

A. All of those factors contribute to the





success of a product.

Q. Or the failure of a product, right?

A. Correct.

Q. Can you really disaggregate one and say that it's more important than the others?

A. Well, I would -- mentioned in my report I think the most important one is the fact that the drug achieves formulary status so the physicians can prescribe it. It has to do the other, it has to be clinically effective and safe and cost effective in order to be placed on formulary.

Q. Right. But there's lots and lots of products that are placed on formulary that don't have very many sales, right?

A. There may be, depending upon market demand and the therapeutic category they're in.

Q. And certainly you'd agree that formulary positioning is no guarantee of successful product sales?

A. Yes.

Q. Let's see, now. You'd agree that the primary demand generators in the pharmaceutical market are physicians who prescribe the product; is that correct?

A. Physicians and patients themselves. They're





becoming more and more educated on -- thanks to direct-to-consumer advertising on products -- and often drive product demand as well as the physician.

Q. And you'd agree, would you not, that thus, manufacturers are incentivized to devote marketing resources to try to encourage physician prescriptions, right?

A. Correct.

Q. And one way that they do that is through detailing, correct?

A. That's correct.

Q. And PBMs attempt to market themselves as able to affect physician prescriptions in some way through their formulary decisions, right?

A. Through their formulary decisions and their physician profiling and their drug utilization review process.

Q. Are you aware of any studies that would -- that would indicate that PBMs, using their formulary processes, are as effective as physician detailing in actually impacting physician prescriptions?

A. I've not reviewed studies to that effect.

Q. Well, as a representative of a PBM, when you're trying to sell your services or trying to encourage manufacturers to give -- to give you rebates





in order to give formulary positions, do you try to -- do you try to convince the manufacturer that you're able to move market share?

A. Manufacturers are already aware that the formulary itself is a tool that will allow them to achieve market share. Or that would prevent them from achieving market share if they can't get on it.

Q. But the extent to which that's the case has not been indicated in empirical studies?

A. I've not seen empirical studies on that.

Q. Now, is it your view that a PBM or an MCO just can't get by without -- without getting rebates from Premarin and Wyeth?

A. As I mentioned in my report, rebates are very important -- important profit component to the PBMs today; and I'm sure they would still exist in the community if they didn't receive rebates from Wyeth, but it would be a significant negative impact on their profitability.

Q. Well, if PBMs actually have the ability to move market share, why wouldn't they simply move market share away from Wyeth products if they weren't getting rebates from Wyeth?

A. Well, it could be an effect that formulary positioning would change if rebates disappeared for

Wyeth products, and which may have an impact then on the Wyeth product market share.

Q. And that would be the PBM's prerogative. For example, if a particular PBM wanted to remove Premarin from its formulary and replace it with Cenestin, it could do so and try to push Cenestin shares, right?

A. They have the -- they would have the ability to do that, yeah.

Q. And you're aware that some plans in the past have removed Premarin, are you not, and have tried to push other estrogen products?

A. Seems to me there was a -- in one of the documents that I read, one of the HMOs, Rocky Mountain HMO, actually put Cenestin on the formulary, and Wyeth discontinued their rebates. I'm not sure whether they took Premarin off formulary or not. But that would be one instance that I specifically am aware of where the rebates went away because Cenestin was put on formulary.

THE VIDEOGRAPHER: Sir, I think your microphone got tugged off or something.

MR. EGGERT: No, I had it in my lap here.

Q. (BY MR. EGGERT) If I could, I'd like to





show you a document which we'll mark as Exhibit 856.

(Exhibit No. 856 marked for identification.)

Q. (BY MR. EGGERT) Are you familiar with an individual by the name of Bill McElroy?

A. I don't recall that right offhand. Bill McElroy. I don't recall Bill McElroy.

Q. Do you recall receiving this document, not the first page, but the remainder of the document in or about January 26th of 1994?

A. I believe I wrote the document.

Q. Okay. So this would be a document that you authored, from the -- from the style of it?

A. Uh-huh.

Q. And this would be something that you wrote to all California stores?

A. In my capacity with Longs Drug Stores, correct.

Q. Right. At that time, were you with their managed care organization, managed care --

A. In 1994, I was their director of managed care services. We did not have a PBM until 1995.

Q. Right. So you were the person that interfaced with MCOs and PBMs?

A. Correct.

Q. And you indicate here under item number 2





here, that the following drugs are no longer covered -- and this is with respect to Prescription Solutions and PacifiCare -- the following drugs are no longer covered unless medically indicated and prior authorized by Prescription Solutions, and one of those is Premarin, and the suggested covered drug to substitute is Ortho-Est and Menest. Do you recall receiving that information from Prescription Solutions in 1994?

A. This information came from Prescription Solutions; and according to the memo -- I don't recall a specific instance of writing it, but I obviously did. According to the memo, it applies just to their retirees and Secure Horizons senior members, not their entire book of business.

Q. And what portion of PacifiCare's business is the Secure Horizons, dash, individual contracts?

A. I can't give you the exact number, but it's a -- it's a smaller portion than their commercial HMO population is.

Q. And do you have any reason to know why it was that they chose to remove Premarin from -- to make it a non-covered drug?

MS. COURVILLE: Are you asking him why Prescription Solutions made that choice?





A. I don't know why they made the choice. They simply gave me the changes to their plan to communicate to our stores.

Q. (BY MR. EGGERT) And you just communicated?

A. Yes.

Q. You never had discussions with Prescription Solutions as to why they chose to do this?

A. No.

Q. But this was an example where one PBM removed Premarin from -- or at least a portion of its formularies, I take it?

A. That's what it appears to be.

Q. And of course, the --

A. They didn't -- looks like they -- they assigned it to a prior auth category,

(Reporter asks for repeat.)

A. A prior authorization category. Changes to the... (Witness reading.)

I can give you an assumption, but I can't tell you why they did it. What they're doing is moving Premarin from an open position to require a prior auth in order to be dispensed.

Q. And then to your knowledge, does AdvancePCS receive any rebates from Premarin at this time?

A. Don't know the answer to that.

Q. You indicate in your report that they no longer have a contract with AdvancePCS -- between the AdvancePCS and Wyeth, right?

A. AdvancePCS, the best of my recollection, documents I read, their contract expired toward the end of 2001, and they added Cenestin to their formulary oh, early in 2002, in the spring sometime.

Q. You're aware that that standard clause in contracts between managed care entities and pharmaceutical manufacturers is to provide for termination -- unilateral termination by either party on 60 to 90 days' notice, generally?

A. I'm aware that they have termination clauses in the contracts, and it may be 60 to 90 days. It may be different time periods.

Q. AdvancePCS didn't have to wait until the end of 2001 to terminate its arrangement with Wyeth; they could have terminated at any time, right?

A. As long as their agreement allowed that type of an out, yes.

Q. Have you reviewed the AdvancePCS agreement?

A. I don't specifically recall what the termination language was in their contract.

Q. Did you read it?

A. I'm not sure if I remember reading that or





not.

Q. Did you read any of the contracts between Wyeth and any of the PBMs?

A. I reviewed a number of the contracts, yeah, probably a dozen to two dozen of the contracts.

Q. Let me turn to that section of your report where you go through a number of the Wyeth documents. I think that's Roman number VI, is it, starting on page 22. Let's see.

If I could, I'd like to show you 14, a document which -- which your counsel indicated is entitled the "Premarin Preemptive Plan."

I'll mark that as Exhibit 857, although I suspect that it's been marked before.

(Exhibit No. 857 marked for identification.)

Q. (BY MR. EGGERT) There you go.

MS. COURVILLE: Okay. And I would just bring your attention to the fact that this has actually been identified with Mr. Schneider as a draft, and another document was produced and was represented by Wyeth to be the final Premarin Preemptive Plan, and this is not that document. Just FYI.

MR. EGGERT: Okay.

Q. (BY MR. EGGERT) Well, if you look at





paragraph number 2 of your -- here on page 22, this is the document you relied on, in any event, in your report, so I take it you are relying on the draft of the preemptive plan rather than the final preemptive plan; is that correct?

A. I was relying on the document number that's indicated here.

MS. COURVILLE: That's okay.

A. The same one.

Q. (BY MR. EGGERT) Right. Did you ever review the actual plan, or is this the one you reviewed?

A. I may have reviewed them both. This is the one that --

Q. This is the only one you remember?

A. This is the one I recall.

MR. EGGERT: Okay. I thank you for that clarification, Miss Courville.

Q. (BY MR. EGGERT) At least insofar as this draft is concerned -- by the way, you don't know what differences, if any, exist between the draft and the final product, I take it?

A. I do not, as I sit here.

Q. If we turn to page 117999 -- let's see. It listed a number of items. The first one was "distance Cenestin from Premarin."





Actually, you deleted some of the things here when you quoted it, right? It should say "distance Cenestin from Premarin, not AB rated, not therapeutically equivalent, not indicated for osteoporosis" you took those parts out, right?

A. I did not list those on my report, correct.

Q. Right. Why didn't you list those parts?

A. They were not relevant to my opinion.

Q. They weren't helpful to the point you were trying to make right?

A. Right. Prem -- Cenestin was not being treated as a generic product, and that's what those two points refer to.

Q. Right. But did you understand the notion of this as -- the very first item in the strategy was to try to convince physicians, consumers and others that Cenestin was not the same as Premarin, to distance it from Premarin, to point out to those entities that it was not an AB-rated or substitutable product; that it was not therapeutically equivalent, that like Premarin -- unlike Premarin, it wasn't indicated for osteoporosis?

A. I'm aware they had the communication plan in place.

Q. Right. And in fact, the largest bulk of

this document deals with that, right? Deals with how to engage in that plan and that educational program to show to the -- to show to the marketplace that Premarin was different than Cenestin?

A. It has a lot of -- a lot of tools and information in the document itself.

Q. Okay. And then -- and then the part that you did quote in full, one of them was "limit distribution, modify shared success." We already talked about that, and you said you don't know the extent to which they were successful in modifying shared success, right?

A. Yes.

Q. The next point, "limit contracting opportunities, quantify value of Wyeth contracts." I take it did you read Mr. Schneider's deposition when he was explaining what this document meant?

A. I read through parts of his deposition. I don't recall exactly his description of how this was to be interpreted by the folks at Wyeth.

Q. You didn't mention that one before; I think the only depositions you mentioned were Mr. Finneran and Mr. Carter. Now you recall reading portions of Mr. Schneider's deposition as well?

A. I'm not sure whether I read Mr. Schneider's





or -- I know I read Marty Carter's and I read one other one. Might have been Finneran or it might have been Schneider, the names are --

Q. Did you read the deposition of anyone who was an employee of Wyeth; I think you indicated earlier you had not?

A. No, those are the only ones I've looked at.

Q. Okay. And those were employees of Duramed or Viking?

A. Yes.

Q. In reaching an opinion as to what the Wyeth's intent was with respect to this draft preemption plan, might it not have been relevant to look at the deposition testimony of the people at Wyeth that were involved in the development of the plan?

A. It would have been information, though I'm not sure it would have changed my opinion on what I saw and the way I felt Wyeth was implementing their strategy in the marketplace, based on the documents that support what their strategies were.

Q. Right. We don't know whether it would change your opinion because you didn't read the depositions, right?

A. Correct.





Q. Do you have an opinion as to what it means when it says "quantify value of Wyeth's contracts"?

A. My opinion on reading that and looking at the tools they developed to take out to the market to measure the impact of their rebates to each plan to me indicates that they're quantifying the value of the Wyeth contracts to their clients where they have rebate structures in place.

Q. And "enforce preferred brand status." Do you have a view as to what that means?

A. In my opinion, means that in the contracts I reviewed, that Premarin was the sole conjugated estrogen, and that was a requirement of the contracts; and it's my understanding that their strategy was to go out and make sure that that was being enforced.

Q. Well, there are some contracts out there, are there not, where it requires that Premarin be listed as a preferred brand, right?

A. Correct, correct.

Q. And it may or may not be the only preferred brand on the formulary, but could be one of a number of brands designated as preferred on the formulary for the ERT category?

A. Correct.

Q. So this could be referring to that, right --





A. Could be.

Q. -- preferred brand status.

A. Could be.

Q. It doesn't say anything about exclusive sole and exclusive conjugated estrogen, does it?

A. Not in that line, it doesn't, no.

Q. Is there anything in this entire draft preemptive plan that says anything about sole and exclusive conjugated estrogen?

A. I'm not sure those words appear in here.

Q. Well, do you get any closer than "preferred brand status"? Is that as close as you get?

A. I probably have to review the document again to answer that question, but...

Q. Again, I gather this document is the core of your opinion, though, related to Wyeth's intent, right, that's the one you referred to?

A. This document together with the documents that describe the interactions between Wyeth and the PBMs that are listed in the report.

Q. Actually, let's take a look at page 118000. Talking about the Cenestin profile. Indicated that at that time, apparently Wyeth thought that there would be a probable 30 to 40 percent cost savings associated with Cenestin? Are you aware that, in fact, Cenestin

came on the marketplace priced essentially at parity with Premarin?

A. I'm aware there was a very small difference between the two.

Q. Is it possible that a product would have been in perhaps a less -- less of a threat to Premarin if it was priced at the same price as Premarin as opposed to at a 30 to 40 percent discount?

A. That's certainly possible.

Are you referring to AWP price or direct catalog price or net price after rebates?

Q. You know, perhaps if you'd looked at the deposition testimony, they would have explained that, but I can't explain it as I'm sitting here. What price would be most relevant to you?

A. Well, if they're talking about cost savings, the PBM would want to factor in not only the product price, but whatever the net effect would be, together with the rebates.

Q. So you'd have to take into account the rebates as well?

A. Yeah. My guess is that they're talking here about direct catalog price. That's the way I would interpret that.

Q. Okay.





THE VIDEOGRAPHER: I have five minutes left on the tape.

Q. (BY MR. EGGERT) Okay. Let's see. If you turn over a few pages, 118002. Kind of a contrast of Premarin and Cenestin, and this is -- once again fits into the category of distancing Cenestin from Premarin. And would you agree with that?

A. I would, yes.

Q. And talks about how Premarin has been the subject of over 3,000 studies; Cenestin has been the subject of one study. Premarin had over 10 million users; Cenestin had been tested on 120 patients. Premarin had been out for 56 years; Cenestin for 6 months, et cetera, et cetera. But nothing in there is talking about sole and exclusive conjugated estrogens on formularies, right?

A. Nothing in here, correct.

Q. Okay. Let's see. The next page, talking about nicheing Cenestin. Basically that's yet another -- that's a distancing Cenestin from Premarin point again? Cenestin is not bioequivalent to Premarin, do you agree?

A. I would agree.

Q. Okay. Just flipping through the pages here, I don't see anything on sole and exclusive conjugated





estrogens. If you see something, let me know.

Page 118007, I think this is more distancing Cenestin from Premarin. Says "no other estrogen is therapeutically equivalent to Premarin; there is no generic equivalent to Premarin." You'd agree that's distancing Cenestin from Premarin?

A. I would, yes.

Q. The next page, the same thing, right? 118008?

A. Yes, uh-huh.

Q. And then the promotion/education plan, do you take that to have anything to do with limiting contracting opportunities or is that still distancing Cenestin from Premarin?

A. That doesn't appear to me to have anything to do with contracting activities.

Q. Okay. If it deals with education, it's probably trying to tell people about the differences between Cenestin and Premarin, right?

A. I would imagine it is.

Q. Then there's something called a Pharmacy Attack Pack. Did you consider that at all in reaching your opinions, the Pharmacy Attack Pack?

A. I didn't factor that into my opinion on the relationship between Wyeth and the PBMs in the





contracting process.

Q. Okay. And once again, this seems to be pushing the principle that all estrogens are not the same and distancing Cenestin from Premarin, right?

A. Correct.

Q. Let's see. I think if we get to the back of the document, we'll find something about the contracts. Here they're mentioning MCOs, at least on this page, 118023, an MCO tactical overview.

(Reporter asks for repeat.)

Q. 118023.

Did you rely upon this page in coming to your conclusions concerning Wyeth's intent in the sole and exclusive conjugated estrogen language?

A. No, I don't recall using this specific page.

Q. Okay. There's some discussion of shared success here. Starting at 118027. But did you see anything inappropriate about these things related to shared success, that it reflected some sort of a malicious intent?

A. No, I did not.

THE VIDEOGRAPHER: I need to change tapes.

MR. EGGERT: Oh, sorry.

THE VIDEOGRAPHER: That's okay.
MR. EGGERT: Change the tape. You did give me a warning.
THE VIDEOGRAPHER: We're off the record at 3:14.
(Short break 3:14 to 3:16 p.m.)
THE VIDEOGRAPHER: We're back on the record at 3:16.
Q. (BY MR. EGGERT) Okay. I'm still leafing through. I notice on page 118032, it mentions once again to quantify the value of the Wyeth contract?
A. Correct.
Q. That's the same language that we had up above, right?
A. Correct.
Q. But it says that is ongoing. It also mentions to sell the science of Premarin and to assess each national account.
Actually, if you look at page 118033 under "Premarin Defense Strategy," and it lists a number of PBMs and HMOs listed as -- what do you understand by the low, medium and high risk there?
A. Those were -- it was my understanding those were PBMs that there was potential risk of losing the formulary status or having them put on another





formulary product.
Q. And I take it, then, with respect to these formularies on the top here which seem to cumulatively account for something like 700 million or more in sales, it was perceived it was a low risk, right?
A. Correct.
Q. And the only ones with the high risk were Provantage and Humana, right?
A. Correct.
Q. And Humana actually signed a formulary agreement ultimately with Duramed, right?
A. Correct.
MS. COURVILLE: Objection, evidences facts not in evidence.
Q. (BY MR. EGGERT) Did Provantage also place Cenestin on the formulary, do you know?
A. I don't recall whether they did or not.
Q. Okay. There's a number of pages on selling the science of Premarin. But once again, that's the message of distancing Cenestin from Premarin, right?
A. Correct.
Q. Here on page 118037, we get some elaboration on quantifying the value of the Wyeth contract. Talking about PacifiCare here. Doesn't mention "sole and exclusive conjugated estrogen" language, does it?





A. That language is not on here, no, these are the tools that, to my understanding, were distributed to all of the national account managers to take out to their accounts to demonstrate the financial value of their current sole-source contracts with Wyeth and to be used as a -- a lever to prevent them from getting Cenestin on their formularies.
Q. Was it a lever to prevent them from getting Cenestin on their formularies or to -- or to tell them what would happen with respect to their rebates as particular percentage shares of their sales were attributable to Cenestin rather than Premarin?
A. That's the method by which they demonstrated the loss would occur, and the -- if they were to violate their sole-source contract, they would lose those dollars by allowing Cenestin to be put on formulary. I think in one of my exhibits, it even indicates that in their discussions with Express Scripts who, in part of their process, went as far as to select Cenestin to be on formulary and was reminded after the fact that they had a sole-source contract, and I think the number was $40 million of annual rebates were going to be at risk if they didn't keep Cenestin off formulary.
Q. But then they did put Cenestin on their





expanded formulary, right, as we saw in the interrogatory response?
A. At a later point in time.
Q. Do you know when that occurred?
A. I do not.
Q. Okay. Now, is it your understanding that Wyeth sales representatives actually went out to each PBM and gave them documents of this sort?
A. I know they did it with a couple of the PBMs. I don't have evidence that they actually reached all PBMs, but I know according to the internal Wyeth documents that it was distributed to all national sales managers to take out and use with their PBMs.
Q. But you don't know whether they actually --
A. I don't know the outcome of the process.
Q. Is this kind of a standard analysis that PBMs would undergo normally in determining whether or not to place drugs on formulary, they would look at effect on -- the total effect on their rebates of shifting percentage sales to a competing product, and they'd look at the competing product's prices and its rebates and compare them to the prices and rebates of the other product and see how it all balanced out?
A. Yeah, an analysis of the total drug cost and

the potential rebates would be part of the process a PBM would go through when they make a decision to put a product on formulary.

Q. And in fact, would the analysis that the PBM would go through, would it actually be a fair amount more sophisticated than the analysis set forth in these documents?

A. It may be similar to this.

Q. Did you engage in that type process when you were at RxAmerica?

A. I think I sat in on a couple of reviews, but I don't recall having any accounts where we -- any pharmaceutical manufacturers where we had multiple products and would lose all rebates or threaten to lose all rebates if one of the products had a competitive product on our formulary.

Q. And is that pretty much it? Talks about state government affairs -- once again, on page 118049, seems like this is once again distancing Cenestin from Premarin, talking about blast faxes and scientific briefings, physician papers?

A. Uh-huh.

Q. The next page, press release "new synthetic estrogen product not equivalent to Premarin." It's not your opinion that anything that Wyeth did in that





regard was exclusionary, I take it?

A. In their communication and media relations --

Q. Right.

A. -- is that what you're asking about?

Q. Right.

A. No. I didn't see them specifically disadvantaging their competitor in those efforts.

Q. How about in DTC advertising? What's DTC advertising?

A. Direct-to-consumer advertising.

Q. That's mentioned on 118052. Does that form part of your opinion, are you --

A. No, that's not included in my opinion.

Q. Okay. And then the last page, "Key Messages." "Not AB rated, not bioequivalent, not a pharmaceutical equivalent, not therapeutically equivalent, no osteoporosis indication, lacks long-term safety and efficacy data, offers just one dose, simply another limited option." It doesn't say anything about sole and conjugated estrogens, right?

A. Correct.

Q. Okay. Now, you mentioned, I guess, a number of things in paragraph 4, I think you're talking about AdvancePCS; is that right?





A. What page are you on?

Q. That's page 23 of your report. And paragraph 4 is essentially devoted to AdvancePCS and its predecessors, I may call them?

A. Correct.

Q. And there were a number of predecessors because there's been a lot of mergers and consolidations in the PBM industry, correct?

A. That's correct.

Q. And PBMs have been getting bigger and bigger; isn't that true?

A. Yes, they have.

Q. And more and more powerful?

A. In what sense?

Q. As they aggregate more and more members?

A. Oh, correct.

Q. They have more power to negotiate both with pharmacies and with pharmaceutical manufacturers, right?

A. Correct.

Q. And they use that to try to get low prices from pharmacies and big rebates from manufacturers, essentially, right?

A. Correct.

Q. And let's see. In paragraph A, you mention





a February 19th, 1999, document to Advance Paradigm. And you talk about how Wyeth is saying that protection -- their position is protected with Advance Paradigm. And then you indicate that -- it says Karl wants to identify partnering strategies and tactics on how we can together with API -- and that would be Advance Paradigm, right?

A. Uh-huh.

Q. -- blunt the launch of Cenestin. Do you know whether Advance Paradigm ever did anything to work with Wyeth to blunt the launch of Cenestin?

A. I'm not aware of the outcome of that information conversation.

Q. Are you aware of -- are you aware of anything called an access agreement? Is that a phrase that you're familiar with?

A. I'm familiar with access agreements or access rebates.

Q. What are access rebates?

A. Rebates that are generally rebates that are paid for allowing a product to be placed on formulary, regardless of their market share.

Q. Actually, let me -- do you have the Drug Cost Management Review? If you'd look on the second page, I think Mr. Nee has a discussion of access

rebates. It's a little bit different than what you've said.

Says the access rebate structure is similar to the flat rebate in that the percentage of the rebate is constant. Manufacturer's goal in using this type of rebate might be to gain a foothold in a PBM's formulary or just to prevent being blocked by the PBM?

A. That's correct. It's a rebate paid to obtain position on the formulary and access to the membership.

Q. Are you aware that Duramed actually negotiated an access agreement with Advance Paradigm by which Advance Paradigm agreed that it would not intervene against Cenestin; and that although the product would not be on formulary, it would be available to consumers at the same co-pay as Premarin?

A. I'm not --

MS. COURVILLE: Objection. There's a date discrepancy that we need to resolve if you're going to ask him questions like that.

Q. (BY MR. EGGERT) Are you aware of such an agreement negotiated?

A. I'm not aware of that, but to me, it wouldn't change things a whole lot. If they're not on formulary, they're still going to be viewed as a





non-formulary product in the eyes of the physicians when they make their prescribing choices.

Q. Are you aware that Cenestin was actually listed in the AdvancePCS formulary?

A. As of when?

Q. As of I think 2000. Not listed as a formulary product, but listed in the formulary.

A. Was it listed as a non -- I'm not aware of how it was listed in that particular formulary. I'm aware that they were listed in the formulary after 2001.

Q. As a formulary product, right?

A. Correct.

Q. If they were actually listed in the formulary as early as 2000 or 2001, might that affect your analysis?

A. Depending on how they were listed.

Q. Now, do you have any understanding as to why it was that Cenestin was not placed on AdvancePCS's formulary -- or PCS's formulary -- I guess at that time, it was PCS, back in 1999?

A. It's my understanding that -- that Wyeth had a sole-source contract with -- are you talking Advance or PCS?

Q. Talking PCS right now.





A. They had a contract with PCS that prevented them from putting Cenestin on formulary or adding another conjugated estrogen to formulary.

Q. Could Cenestin have obtained placement on the formulary if they just obtained a placement as -- identified as just an estrogen and not as a conjugated estrogen?

A. I don't know the answer to that.

Q. You've not explored that in reaching your opinions?

A. Correct.

Q. And let me show you a document which I'll mark as Exhibit 858, and this is a document produced by PCS HealthSystems.

(Exhibit No. 858 marked for identification.)

Q. You know, I should say that the entirety of this deposition transcript in the interim period should be designated as highly confidential because we're using various parties' documents, including here PCS's. And I suspect that most of it will probably remain confidential.

Is this a document that you've seen before?

A. It is not.

Q. These purport to be the minutes of a pharmacy and therapeutics committee meeting dated





September 15th of 1999, and I think portions that did not relate to Cenestin were redacted by PCS from the production. But if you look under item number 2 on page 2 of the document, it indicates that, "Cenestin is indicated in the treatment of moderate to severe vasomotor symptoms associated with menopause. Cenestin contains 9 synthetic estrogenic substances derived from soybeans and yams. In a 12-week clinical study, Cenestin demonstrated daily, 77 percent were on 1.25-milligram daily by week 12," et cetera, et cetera.

They mention that there is no discount on the product. They say that despite its derivation from natural sources, the committee member thought there were enough other options for hormonal replacement that Cenestin would not be necessary.

The ob/gyn committee member was unsure what benefits Cenestin had over Premarin. And further down, the member also stated that although there are no comparison studies, it may be that twice as much Cenestin versus Premarin may be required to relieve vasomotor symptoms. At a 1.25-milligram comparative dose, Cenestin is 40 percent more expensive than Premarin. The committee voted not to add Cenestin to formulary.

So does this analysis from PCS indicate that Wyeth's "sole and conjugated exclusive estrogen" language had anything to do at all with the decision not to place Cenestin on PCS's formulary?

A. Not this document.

Q. Do you know of any document that suggests that -- that the "sole and exclusive" language was the reason that PCS didn't place Cenestin on the formulary?

A. It's my understanding that the -- the agreement that Wyeth had with PCS also indicated that Premarin would be the sole conjugated estrogen on formulary with their plan.

Q. But even if it had indicated otherwise, according to this document, the Cenestin wouldn't have been on the formulary, right?

A. This also supports Cenestin's non-formulary position.

Q. All right. Let me show you the document that we've already marked as Exhibit 852. Is that it?

MS. WIEGAND: Yeah.

MR. EGGERT: Is this the actual original? I guess this is. Here's a copy. 852. That was the -- the memo from Mr. Neeley to Mr. Carter





attaching various things. The one that had talked about how RxAmerica hadn't put it on formulary.

Q. (BY MR. EGGERT) If you look at the first item there under PCS Health Systems on page 10671, it indicates that for the year 2000, PCS has decided to table the discussion and review of Cenestin for inclusion into their performance drug program. This decision was due to the unavailability of the 1.25-milligram strength, which comprises nearly 25 percent of their Premarin utilization.

So there's nothing in there that suggests that the decision even as of 2000 had anything to do with the "sole and the exclusive conjugated estrogen" language, but it was focusing more on the lack of availability of the 1.25-milligram strength?

A. (Witness reading.) What was your question, again? I'm sorry, I finished reading the rest of the document here.

Q. Right. Once again, there's no suggestion here that the reason that PCS did not place Cenestin on the formulary was because of the contractual language with Wyeth, but instead, it focuses on the lack of the 1.25-milligram strength, correct?

A. That's what this particular document indicates.





Q. And this particular document also indicates that notwithstanding the fact that Cenestin was not on the formulary, that it would be available at the same co-pay as products accepted for inclusion on the formulary, such as Premarin, with respect to 90 percent of PCS's book of business, or over 45 million lives, right?

A. That's what it says, uh-huh.

Q. So with respect to those 45 million lives, they could still get Cenestin by paying the same co-pay as Premarin, right?

A. That's what it indicates.

Q. And in fact, in the last paragraph, it indicates that Viking, the managed-care experts hired by Duramed, actually continued to recommend a strategy without an agreement because it provided extensive Cenestin coverage with no rebate liability. What do you understand by that statement?

A. Oh, just what it says, it allows some access without Cenestin having to pay a lot -- pay rebates. It also indicates up in the prior paragraph, just about the last sentence, that pharmacists will receive an on-line message indicating the status of Cenestin as a non-formulary product. They are told not to intervene.





Well, so they're still sending out an on-line message indicating it's non-formulary.

Q. But they're told not to intervene and they're told to dispense Cenestin as written, is what it says, right; that what's it says?

A. Yes. It doesn't indicate that's part of the on-line process. The on-line process is pretty brief messaging. I don't know how they get all of that on there.

Q. How can you read that sentence as anything else other than that? "Pharmacists receive an on-line message indicating the status of Cenestin is a non-formulary product, but are told not to intervene, and dispense Cenestin as written." Do you think they give the pharmacists a telephone call; is that what that means?

A. No, it could mean they communicate corporately that although that message is coming across, let your pharmacists know that they can still dispense as written. Could be interpreted different ways, is what I'm saying.

Q. You don't know one way or the other?

A. I don't. But it does indicate that the on-line message indicating Cenestin is non-formulary is quite clear.

Q. Let's look down at Aetna/US HealthCare right below. It indicates that Cenestin would not be included on the 2000 drug formulary exclusion list, so it wouldn't be actively intervened against; and also indicated that for the majority of Aetna plans, Cenestin will be covered and reimbursed at a standard co-pay level and not actively intervened against.

So that was another plan where Cenestin would be available at the standard co-pay, right?

A. Correct, but not included in the formulary.

Q. All right. And in United Health Care on the next page, which is connected I think with -- with that --

MS. COURVILLE: Dave, is there a question in here somewhere?

MR. EGGERT: Yes.

Q. (BY MR. EGGERT) The next page, it says, "At this time, Cenestin is considered non-formulary"?

A. What page are you on? I'm sorry.

Q. The next page, 10672.

A. Okay.

Q. "Cenestin is considered non-formulary, however, is being reimbursed in the majority of their plans at the $13 co-pay level." Reading this, is it your understanding that this was -- even with respect





to what were normally three-tier plans, Cenestin was available at the standard co-pay level?

A. That's what this indicates.

Q. And you didn't take that into account in connection with reaching your opinions in your report, right?

A. No, what I would take into account, that it's still considered a non-formulary product.

Q. Why is it that being on the formulary is considered the holy grail?

A. Being on formulary indicates to the physicians that it's okay to dispense it. And they can include it in their products, their 20 or 30 drugs they formally prescribe as products they know are not going to be stopped because they're non-formulary. So formulary positioning is very important in the industry for the manufacturers as well as for the physicians.

Q. Do you think that most physicians actually even examine the formularies that are sent to them by PBMs?

A. I think physicians learn -- I think some of them do. I also think that physicians learn by exception that when they get a few phone calls on a product, they know that that's not a product on





formulary for most of their plans.

Q. But they won't be getting a phone call if it's being reimbursed at the same co-pay level as Premarin, will they?

A. With this particular plan, they won't, but they may be getting it with their other plans that do not have a similar co-pay if that, in fact, is the case.

MS. COURVILLE: I'm going to object to this entire line of questioning to the extent it's irrelevant to any of the opinions that this expert will offer.

MR. EGGERT: That might be true, because he appears to have no opinion on the actual effect of anything that Wyeth did.

MS. COURVILLE: He's told you what his opinions are.

MR. EGGERT: Yes. He has.

Q. (BY MR. EGGERT) Let's see if I could direct your attention to page 24, subsection f. What you said in subsection f there appears to be identical to the language in the document that you've cited in subsection d, which is the immediate top of that page.

Was there a reason that you found it





necessary to cite the exact same language regarding the exact same situation twice within two paragraphs in your report or was that just a mistake?

A. It may have just been redundant.

Q. Okay. If you go to number h on page 25, we're talking about Alan -- I think you spoke with Alan at Health Net earlier?

A. Alan Jacobs, correct.

Q. And he was the one you thought had said that there actually -- that there was some actual activity going on against Cenestin, right?

Let's see. And he says here, "Alan is aware of the exclusionary language in our contract, and given the limited indications for the Cenestin product, did not see a role for it on formulary."

So that statement is consistent with -- with Alan not seeing a place for it on the formulary because of the limited indications that the Cenestin product had, right?

A. That's according to the language of the Wyeth person that was reporting on that memo.

Q. Right.

A. Also indicates that they'll continue the NDC blocks and keep Cenestin from being made available.

Q. At least that's a prediction that this Wyeth

person said?
A. Correct. It will be blocked; and Alan indicated that it would stay blocked and not available, which to me indicates that there was an NDC block in place.
Q. Is Health Net a highly -- is it a closed plan?
A. It's not a staff model plan like a Kaiser (phonetic). They have an HMO program and they have more open plans as well.
Q. Are they -- where are they located?
A. Health Net is located in Woodland Hills, California.
Q. Let's see. Down to subsection j here, quoting from another internal Wyeth memo -- by the way, do you have any idea who the persons were who were writing these memos?
A. No, I do not. They were Wyeth employees.
Q. Would it make any difference to your opinion as to what sort of employees they were, whether they were, you know, lowest-level rung employees or whether they were the upper-echelon employees?
A. Wouldn't make a big difference. To me, they still represent Wyeth in their activities out in the marketplace when they're interfacing with the major





health plans and PBMs.
Q. And you'd have the same view with respect to RxAmerica, that whatever some small employee does has as much impact or as much relevance as something that you did as the manager and the CEO of the organization?
A. Could very well be, correct.
Q. Now, at the end of that subparagraph, it states "Until a specific plan requests the product or a P & T review occurs, the product will be non-formulary and listed as 'NDC not covered.'" Is there anything unusual about that?
A. No, that's not unusual.
Q. And do you know whether a specific plan at IPS ever requested the product?
A. I have no knowledge of that.
Q. And do you know whether a P & T review occurred?
A. I'm not familiar with that, either.
Q. Let's see. If you turn over to page 26, paragraph n, it states, "if we can adjust the baseline on a quarterly basis, we will have an incentive for IPS and the plans to NDC block Cenestin and, where necessary, place the product in highest co-pay category." This is a Wyeth employee suggesting that





they might adjust the baseline in order to incentivize IPS to block Cenestin; is that correct?
A. Correct.
Q. Do you know whether Wyeth ever adjusted the baseline?
A. I'm not aware of the outcome.
Q. And you don't know whether or not there was any NDC blocks of Cenestin and IPS?
A. Correct.
Q. And let's see under p, also, you have in brackets, "Wyeth was able to exclude Cenestin from Advance's formulary until its contract expired in December of 2001. Cenestin was subsequently added to Advance PCS's formulary in February 4th, 2002," correct?
A. Right.
Q. But you don't know of any reason Advance PCS couldn't have terminated that agreement at any time, right?
A. Correct.
Q. Now, I guess paragraph 5, you talk about Medco, right, the second largest PBM in the country?
A. Yes.
Q. And is it your understanding that Medco had an agreement with Wyeth that required Premarin to be





the sole and exclusive conjugated estrogen on the formulary?
A. That's my understanding.
Q. If, in fact, your understanding in that regard is incorrect and they could have changed and added other products to the formulary, would that affect your opinion?
A. I'd have to know more about exactly what it was you were talking about.
Q. But you'd want to consider that, I take it?
A. I would be open to reviewing that information.
Q. And then I guess under subparagraph c, this is the language I think that you -- that you talked about --
A. Are we on page 27?
Q. Page 27, yes. In which the amount of the rebate is proportional to the extent to which the market share of -- you have Cenestin, and then four dots, "is below the national market share of such products for such contract quarter"? In fact, there are a number of other products listed after Cenestin --
A. Absolutely there were other competitive products they were targeting.

(Court reporter asks for repeat; discussion held off the record.)

MR. EGGERT: You want to read back the question so he can answer?

(Question read.)

MS. COURVILLE: And then you said it's true that there were other products.

Q. (BY MR. EGGERT) It's true that there were other products listed where the three -- the four dots are in addition to Cenestin, right?

A. That's correct.

Q. But you took those out in putting them into this document?

A. I did, yes.

Q. And it would have been the cumulative market share of Cenestin and those other products that would have triggered the percentage rebates under this contract language?

A. It was my understanding that it was the market share of Cenestin or each of the other products.

Q. Well, then what would be the rebate? Would the rebate be determined by the market share of Cenestin or the market share of the other products? There's only one rebate, right?





A. It may be -- it may be lumped together. The math that followed this was slightly difficult to understand what they're trying to achieve in the fact that they were targeting a program to pay Medco for reducing the market share of their competitive products, which also included Cenestin.

Q. And once again, you don't -- you don't know whether that language originated with Medco or with Wyeth, I take it?

A. I do not know where it originated. It was in the Wyeth memo.

Q. You mean it was in the document here, the amendment to the agreement?

A. Correct. Yes.

Q. Which both parties signed.

MR. EGGERT: Why don't we take a break for just a few minutes, and I'll go over this stuff? Might not have all that much longer.

MR. COURVILLE: Okay.

THE VIDEOGRAPHER: We're off the record at 3:50.

(Short break 3:50 to 4:17 p.m.)

THE VIDEOGRAPHER: We're back on the record at 4:17.

Q. (BY MR. EGGERT) Sir, if I could direct your





attention to paragraph 32 -- page 32, paragraph 10 of your expert report, and you indicate that in some instances where Wyeth felt Premarin's exclusive formulary position was at risk with a PBM HMO client, Wyeth revised their agreement to increase the rebate dollars paid to the client and lowered the market share performance requirement for their client to achieve the increased rebate amounts.

Is your point here that Wyeth essentially gave the PBMs or the HMOs a better deal and greater rebates than they previously had in order to maintain its status with that account?

A. That's my opinion, yes.

Q. And thus, that the -- the presence of Cenestin and the potentiality of their contracting with Cenestin led to greater rebates for the MCOs and the PBMs, right?

A. To protect their rebate -- to protect their formulary position, they enhanced their rebates to the MCOs, correct.

Q. Is it your experience generally in the pharmaceutical industry that pharmaceutical manufacturers compete with one another in offering greater rebates in order to enhance their formulary position vis-a-vis their competitors?





A. That occurs from time to time.

Q. And is this an example of that?

A. Well, they really had no competitor in this case because the competitor had never made it to formulary positioning. They already owned the formulary position as Premarin.

Q. But the presence of the competitor out there, as you say, caused them to -- competitor waiting in the wings, so to speak, caused them to offer greater rebates to the MCO and the PBM, right?

A. They wanted to -- yes, that's correct. They wanted to protect their position with the PBMs.

Q. And further on, I guess down with respect to Aetna, indicate that Aetna had received -- this is paragraph C, Aetna received rebates for Premarin of 3 percent. And Charles proposed if Aetna agrees to include additional language regarding blocking of Cenestin, then Wyeth should in turn reinstate the 3 percent Premarin rebates. So in essence, they were getting a 3 percent rebate; is that right?

A. The way I read that was that the -- back in 1997, they were at that 3 percent level, and with the signing of the contract subsequent to that, they took those rebates away. And Wyeth was proposing internally that if Aetna would agree to do certain

things to block Cenestin, they would, in turn -- Wyeth would in turn reinstate those 3 percent rebates that they used to receive.

Q. And did that happen?

A. I can -- I can only assume it did. I don't have the outcome of that conversation.

Q. And in fact, in subparagraph d, it talks about how the dollar increase with the new amendment would come to $800,000 for quarterly rebates; is that right?

A. That's correct.

Q. So that was $800,000 in additional rebates that Aetna was getting because of the presence of Cenestin in the marketplace, right?

A. That was an increase of rebate dollars they received, correct, because of the renegotiation.

Q. Let's turn to page 33, subparagraph f, there's a discussion about Caremark here. What's your understanding about -- what was the situation with Caremark?

A. My understanding was based on this, Wyeth -- on this information from Duramed, that Caremark had a lucrative contract with Wyeth for Premarin.

Q. Your understanding, had they had that lucrative contract for a long time? Had it preceded





the entry of Cenestin into the marketplace?

A. I interpreted this to mean that based on Wyeth's last proposal, it appears that they will go with the Premarin and that that contract would net them over a million dollars in gross profits annually based on the proposal that Wyeth gave them.

Q. And was Cenestin trying to get on Caremark's formulary at the same time here?

A. I can only assume it was.

Q. Do you know anything about Caremark's situation other than what you've read in this document that you reference in subparagraph f?

A. I do not.

Q. If I could direct your attention to document previously marked as Defendant's Exhibit 120. It -- has one already. Is there another copy of it?

MS. WIEGAND: Yes.

MS. COURVILLE: Thanks.

Q. (BY MR. EGGERT) This is a Viking managed care update which Miss Courville has seen numerous occasions, and if I could direct your attention to page 736 and 737 and the discussion of Caremark, it's towards the bottom of 736, said that "Dan said that the contract would net Caremark more than a million dollars in profits annually. He felt there still





might be an opportunity for Cenestin with Caremark. However, with the sole and exclusive clause in the contract, I don't share this view." So apparently the author of this document was disagreeing with the person who he'd be dealing with at Caremark about that issue.

"I would not pursue a position on their PBM side without access to the mail, since there are virtually no controls or benefits of contracting for their PBM business. Therefore, I would NOT recommend contracting with Caremark, even if we have that option, (which is questionable)."

So here, at least, Viking is recommending that they not even contract with Caremark, right?

A. That's what the memo indicates.

Q. All right. Let me see. If I could, I'd like to show you this document, which I'll mark as 859, and probably because of my obvious technological limitations, when I printed this off the Internet, some of the spacing was a little bit spasmodic.

(Exhibit No. 850 marked for identification.)

Q. But I printed this off RxAmerica's website yesterday. And it talks about the preferred formulary list. Are you aware of a preferred formulary list of -- that RxAmerica has?





A. Yes, I am.

Q. What is the purpose of the preferred formulary alternative list?

A. The preferred formulary alternative list is a -- in those cases where there are open formularies, drugs that fall within the preferred status provide a higher rebate as opposed to the non-preferred drugs.

Q. So the way that one determines whether you get on the preferred is whether they offer a higher rebate; that's not linked to their AWPs, I take it?

A. Lower cost overall, which often has higher rebates involved with that.

Q. And in the estrogen category, it appears that the preferred alternatives at RxAmerica are Estraderm and Vivelle; is that correct? That comes up with respect to the substitutes for the non-preferred drugs of Climara and VivelleDOT?

A. That's what this indicates, yes.

Q. So to your knowledge, is Premarin a preferred alternative?

A. Not according to this list.

Q. And Cenestin is not listed as a non-preferred drug?

A. Is this the only page?

Q. Yeah, the only page I found, yes. And it

appears to go A through Z, so seems fairly complete.

Do you have continuing responsibilities with respect to RxAmerica or are you still on that planning board or oversight board?

A. The -- I am no longer on the operating committee and have no further activities with RxAmerica.

Q. But they're still affiliated with Longs?

A. They're owned 100 percent by Longs now.

It appears from the heading that this doesn't include all of their therapeutic categories. It says "for several therapeutic categories."

Q. Do you understand --

A. As you can see down the "preferred alternative" listing, whenever possible, they do indicate that a generic drug be used, and this is a low-cost alternative recommendation.

Q. Are Estraderm and Vivelle generics?

A. I don't know whether they're generics or not; they're not indicated as such on the list.

Q. Right. The generics are listed with an asterisk, and they don't have an asterisk by them, right?

A. Right, they have generic equivalents on formulary.





Q. Okay. Put that aside.

(Sotto voce discussion, Defense table.)

MR. EGGERT: Let me mark this as Exhibit -- am I on 860 now?

(Exhibit No. 860 marked for identification.)

Q. (BY MR. EGGERT) This is an e-mail from David Messina of Duramed to Marty Carter, stating that Joe LaPine is no longer involved in contracting. And now he's dealing with someone named -- is it Doug Burgoyne, perhaps?

A. Doug Burgoyne is a clinical pharmacist, uh-huh.

Q. And he indicates in November of 2000 that their formulary is closed. Is that correct, by the way, is RxAmerica -- does it have a closed formulary?

A. I think what this probably refers to is that -- and I don't recall the specific date, but somewhere in -- in between 2000, 2001, RxAmerica changed their formulary process from negotiating directly and internally to using a formulary that was developed by WellPoint and using their formulary and rebate services, and that -- that may be why it indicates that Joe is no longer involved in contracting.

Q. So if Cenestin is now on Wellpoint's





formulary, it should also be on RxAmerica's formulary?

A. It may be. It doesn't have to line up drug by drug. They tried to do the best in aligning them when they went to WellPoint's formulary.

Q. Because I don't believe that currently Cenestin is listed on RxAmerica's formulary, but it is listed on Wellpoint's.

A. It may not be on RxAmerica's formulary. Just because they rent the formulary service doesn't mean it's going to match drug by drug.

Q. And it appears that Mr. Burgoyne is indicating to Mr. Messina that there has to be a demand, and there is just no market share now. Is it uncommon for PBMs to demand that there be some demand or market share for a drug before they place it on formulary?

A. Not uncommon, no.

Q. What would be the logic of that?

A. The PBM would want to know that there's -- that the physicians are going to be wanting to utilize the products or the members are going to demand them or somebody wants it out in the marketplace.

Q. It's frequently the case, then, that a product is able to generate some demand for itself in the marketplace without first being on formulary and





thus to encourage the PBMs to place it on formulary, right?

A. That happens sometimes.

Q. Do you -- do you anticipate doing any other additional work to prepare your work or your opinion in this case or are you finished?

A. I may do additional work depending upon what Duramed would like me to do as the -- as we progress to trial.

Q. But at this time, you have no specific plans of -- specific projects or other things that you are planning to do?

A. That's correct.

MS. COURVILLE: You mean in terms of his report that -- any -- you asking him about a supplement report or --

Q. (BY MR. EGGERT) You're not planning on doing a supplement report, are you?

A. As I sit here today, I have no plans for additional reports unless I'm requested to do that.

Q. And even apart from a supplemental report, you don't have any plans to do additional research or to look at different documents or things of that sort to bolster the opinions that you've expressed in your report to date?

A. Not as I sit here today, no.
Q. Do you have any understanding with Duramed or with counsel as to a cap as to the amount of hours that you can spend on the case?
A. No.
Q. And do you intend to appear in Cincinnati to testify in this case early next year?
A. If I'm asked to do so, that would be my intent.
MR. EGGERT: Take just a second here just to make sure I'm not missing anything.
MS. COURVILLE: Go off the record.
THE VIDEOGRAPHER: We're off the record.
(Brief break at 4:33 p.m.)
THE VIDEOGRAPHER: We're back on the record at 4:33.
Q. (BY MR. EGGERT) Sir, I appreciate your time -- just a couple more questions. Have you reviewed the reports of the other experts that Duramed has retained in this action?
A. I have reviewed a report from Dave Gibson, a report from Steve Schondelmeyer, a report from a pharmacoeconomist.
MS. COURVILLE: Dr. Leitzinger?





A. Dr. Leitzinger. I've seen their reports.
Q. (BY MR. EGGERT) And do you have any views on the accuracy of the information contained in their reports?
A. I have nothing to comment on their reports.
Q. Do you rely in any way on their reports in reaching your own conclusions?
A. I did not.
Q. Did you and Mr. Gibson discuss your reports -- or Dr. Gibson discuss your reports with each other before they were submitted?
A. We knew that we were both working on reports and that his was focused on the physician area and mine was focused on pharmacy and PBM.
Q. Did you have conversations with Dr. Gibson about the substance of your report?
A. Not necessarily, no.
Q. What sort of conversations did you have with Dr. Gibson about your report?
A. We talked about the fact that originally, he was the first person contacted by Duramed through Susman to create a report that was inclusive of pharmacy and PBM information; and then he quickly realized that that's not where his expertise was, and recommended they contact me for that. So then I told





him that I would be working in that area, and those are the expert opinions I would render based on things in those two areas, and his would be focused on physicians and the physician-prescribing activities.
Q. Did you agree to take on this job as a favor to Dr. Gibson?
A. No.
Q. And did -- have you had any conversations with Schondelburg?
A. Schondelmeyer. I have not, no.
Q. Lightheiser?
A. No.
Q. All these names, very confusing for me. You've not had any conversations with a Mr. Ostberg, have you?
A. No.
Q. Have you looked at the Ostberg report, just a survey of physicians?
A. (Shaking head.)
Q. No?
A. Let me rephrase that. I looked at a survey that was done, a telephonic survey that was done with physicians. I don't know if that's the one you're referring to or not.
Q. Are you relying upon that survey at all in





connection with your opinions in this case?
A. No.
Q. Okay. Well, I don't have any further questions for you at this time, sir.
A. Okay.
MR. EGGERT: It's been a pleasure. Thank you very much. And subject to -- I think there were two documents that I mentioned that we'd like to receive; and subject to any further questions that I might have based on those documents, which I think is doubtful, I'm completed, and I take it there's no --
MS. COURVILLE: No questions at this time.
THE VIDEOGRAPHER: We're off the record at 4:36.
(Record closed 4:36 p.m.)

CHANGES AND SIGNATURE

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THE STATE OF TEXAS :
COUNTY OF HARRIS :

I, SUSAN T. BAKER, a Certified Shorthand Reporter and Notary Public in and for the State of Texas, do hereby certify that the facts as stated by me in the caption hereto are true; that the above and foregoing answers of the witness, DALE BYSTROM, to the interrogatories as indicated were made before me by the said witness after being first duly sworn to testify the truth, and same were reduced to typewriting under my direction; that the above and foregoing deposition as set forth in typewriting is a full, true, and correct transcript of the proceedings had at the time of taking of said deposition.

I further certify that I am not, in any capacity, a regular employee of the party in whose behalf this deposition is taken, nor in the regular employ of his attorney; and I certify that I am not interested in the cause, nor of kin or counsel to either of the parties.

GIVEN UNDER MY HAND AND SEAL OF OFFICE, on this, the 23rd day of July, 2002.

_____
SUSAN T. BAKER, CSR, RDR
Notary Public in and for
Harris County, T E X A S

My Commission Expires: 11/26/03
Certification No.: 1561
Expiration Date: 1/7/06

Team Litigation Company
3605 Katy Freeway, Suite 100
Houston, Texas 77007
713-802-9100





I, DALE BYSTROM, have read the foregoing deposition and hereby affix my signature that same is true and correct, except as noted above.

_____
DALE BYSTROM

THE STATE OF _____)

COUNTY OF _____)

Before me, _____, on this day personally appeared DALE BYSTROM, known to me (or proved to me under oath or through_____) (description of identity card or other document) to be the person whose name is subscribed to the foregoing instrument and acknowledge to me that they executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this _____ day of _____, ____.

_____
Notary Public in and for
The State of _____

My Commission Expires: _____

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